

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10103

CERTIFICATE OF DEATH

11541

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>32 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg RFD #1 Box 278</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Reginald</u> Middle <u>Lyden</u> Last <u>Bolden</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1967</u>
9. AGE (In years lost birthday) yrs. <u>15</u>		IF UNDER 1 YEAR Months <u>15</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Reginald Lee Bolden</u>		14. MOTHER'S MAIDEN NAME <u>Gretha Bolden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Reginald L. Bolden, Federalsburg, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia respiratory</u> <u>7571</u> DUE TO <u>and Cardiac failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bilateral poly cystic Kidneys</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1967</u> , to <u>1967</u> , that (I) (we) last saw the deceased alive on <u>1967</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>A. Mehri</u>		22b. DATE SIGNED <u>8/5/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ali. Mehri</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 5, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Federalsburg, Maryland</u>	
24. FUNERAL DIRECTOR <u>Frankton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Federalsburg Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>		DATE <u>AUG 18 1967</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10104

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10106

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton (Rural)			c. LENGTH OF STAY IN It 41 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton (Rural)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #3				d. STREET ADDRESS RFD #3		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cecilia Marta P. Bonga				4. DATE OF DEATH Month July Day 4 Year 1967			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/12/1885	
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Pietra P. Bonga, Cambridge, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO (b) Age Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Louis Merty EXAMINER'S NAME (Type) INELTY			22. DATE SIGNED 7-7-67				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7/8/1967		23c. NAME OF CEMETERY OR CREMATORY Landing Neck		23d. LOCATION (City or Town) (County) (State) Easton, Md.
24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md.				25a. REC'D BY REGISTRAR DATE JUL 10 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10105

CERTIFICATE OF DEATH

10107

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN It <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>				d. STREET ADDRESS <u>522 GOLDSBOROUGH STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>ROSE</u> Last <u>BOWMAN</u>				4. DATE OF DEATH Month <u>July</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 30, 1885</u>		9. AGE (In years, last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ORGANIST, PIANOTEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MILTON HENDERSON</u>				14. MOTHER'S MAIDEN NAME <u>IDA ROSE BASSETT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-12-5807</u>		17. INFORMANT <u>MRS. L. ELBERT GADEY</u>		Address <u>EASTON, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334X</u> DUE TO <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Due to Retired</u> DUE TO <u>Chronic Cerebral Vascular Dis.</u> (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-10-67</u> , 19 <u>67</u> , to <u>7-14</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7-14</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> AM, from <u>Natural</u> causes and on the date stated above.							
22a. SIGNATURE <u>R. Lane Wroth</u>				22b. DATE SIGNED <u>7/15/67</u>		22c. PHYSICIAN'S NAME (Type) <u>R. Lane Wroth</u>	
22d. ADDRESS <u>Easton, Md. St. Michaels, Maryland</u>				22e. M.D. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>JULY 17, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>EASTON TALBOT MD.</u>	
24. FUNERAL DIRECTOR <u>John Seal</u>		ADDRESS <u>Easton Md</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

REPORT OF THE

1907

COMMISSIONER OF

THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

PASSED BY THE SENATE

ON JANUARY 10, 1907

ALBANY:

THE UNIVERSITY OF THE STATE OF NEW YORK

PRINTING OFFICE, 1907

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be the main body of the report, containing various sections and paragraphs.]

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10106

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10108

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>2 hr. 40 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>		201	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wendell Phillips Bradley</u>				4. DATE OF DEATH Month <u>July</u> Day <u>13</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/13/1927</u>	9. AGE (In years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, if retired) <u>Author and Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Phillips Bradley</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Pickering</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>004-24-3243</u>		17. INFORMANT <u>Edward Bradley, Bethesda, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> DUE TO <u>Lacerations of Right Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multiple fractures ribs</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> a.m. <u>12</u> p.m. <u>July</u> <u>1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, store, street, office, etc.) <u>Route 33</u>		20f. (City or town) (County) (State) <u>Sherwood Talbot Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Kevin Q. Mundy</u>		EXAMINER'S NAME (Type) <u>INELTY</u>		M.D. <u>for</u>		22. DATE SIGNED <u>7-13-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>7/19/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Maurice E. Keenan-Syn</u>				ADDRESS <u>LA-tow. Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 21 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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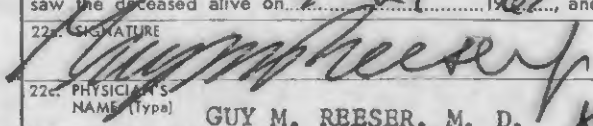
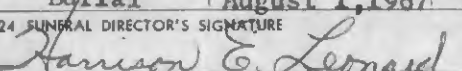
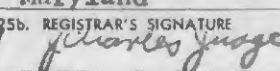
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10107

10109

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Bozman c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -----				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Bozman d. STREET ADDRESS -----			
3. NAME OF DECEASED (Type or print) ROBERT HAROLD BRINK			4. DATE OF DEATH Month July Day 30 , Year 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1899	9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. _____	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Doctor		
10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Kingston, New York		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Arthur Brink			14. MOTHER'S MAIDEN NAME Fannie Best				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I & WW II		16. SOCIAL SECURITY NO. 235 - 70 - 0045		17. INFORMANT Mrs. R. H. Brink, Bozman, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction DUE TO atherosclerotic coronary art. d. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH 		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) 	(County) 	(State) 		
21. I certify that (I) (this hospital) attended the deceased from 2-4-1966 to 2-30-1967 , that (I) (we) last saw the deceased alive on 2-29-1967 , and that death occurred 4:30 p.m. from the causes and on the date stated above.							
22a. SIGNATURE  22c. PHYSICIAN'S NAME (Type) GUY M. REESER, M. D.			22b. DATE SIGNED 7-31-67 22d. ADDRESS St. Michaels, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 1, 1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park	23d. LOCATION (City, town or county) Boston, Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE  25a. REC'D BY REGISTRAR AUG 1 1967			25b. REGISTRAR'S SIGNATURE 				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

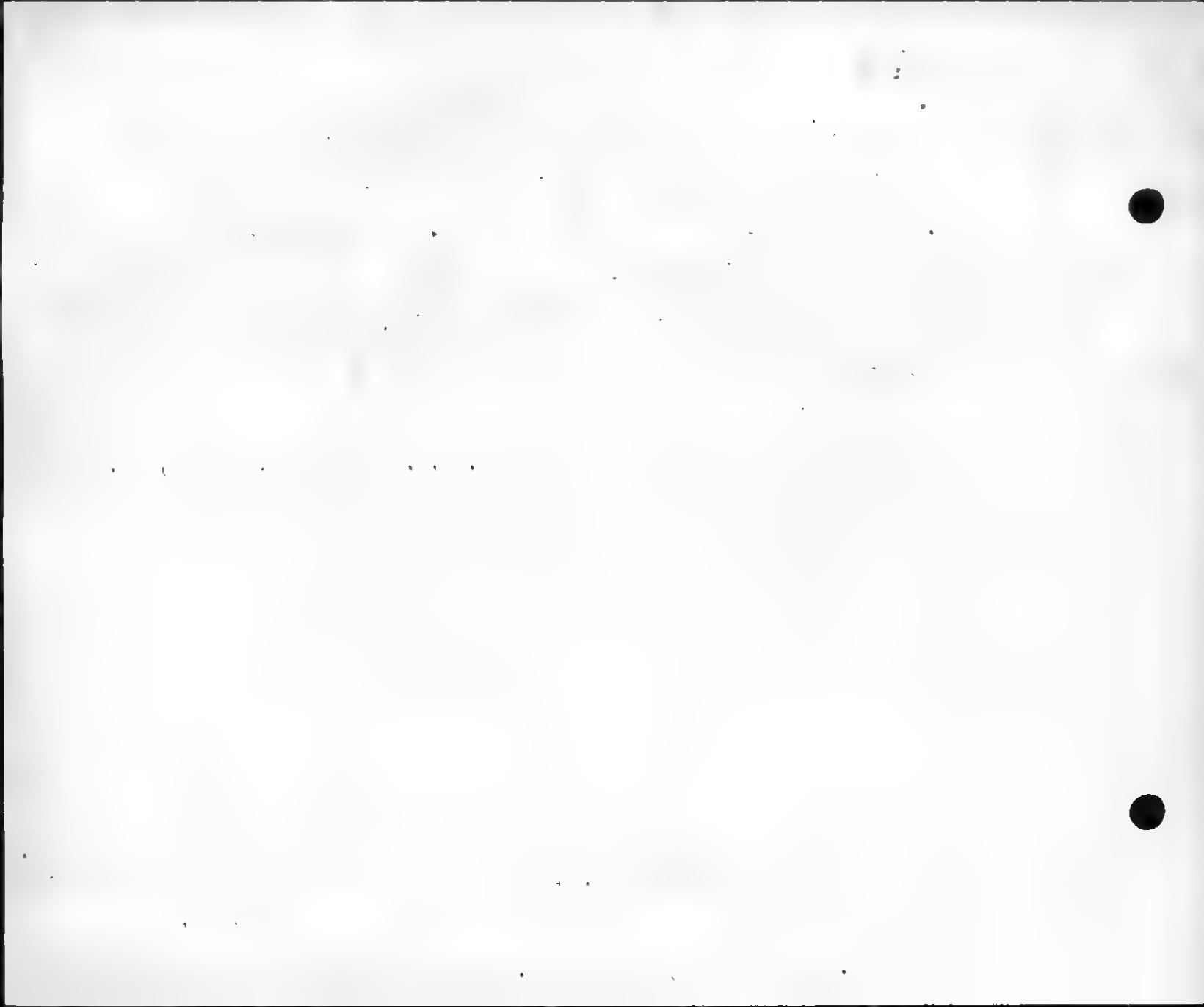
10103

CERTIFICATE OF DEATH

10110

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Talbot</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>				c. LENGTH OF STAY IN TB <i>20 years</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>N. Washington Street</i>				d. STREET ADDRESS <i>N. Washington Street</i>			
3. NAME OF DECEASED (Type or print) <i>Nora Morris Callahan</i>				4. DATE OF DEATH Month <i>7</i> Day <i>25</i> Year <i>1967</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/24/1881</i>		9. AGE (In years last birthday) <i>86</i> yrs	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Ireland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Morris</i>				14. MOTHER'S MAIDEN NAME <i>Bridget Burke</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO		17. INFORMANT <i>Mrs. P.J. Fitzgerald, Easton, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO (b) <i>Arterio Sclerotic Heart Disease</i> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <i>2 mo</i>	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7-25-67</i> to <i>7-25-67</i> , that (I) (we) last saw the deceased alive on <i>7-25-67</i> , and that death occurred at <i>3:40 AM</i> , from causes and on the date stated above.							
22a. SIGNATURE <i>Harry M. Walsh, M.D.</i>				22b. DATE SIGNED <i>7/27/67</i>		22c. PHYSICIAN'S NAME (Type) <i>Harry M. Walsh, M.D.</i>	
23a. BURIAL, CREMATION, or other disposition <i>Buried</i>		23b. DATE THEREOF <i>7/27/1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>		23d. LOCATION (City or town) (County) (State) <i>Easton, Md.</i>	
24. FUNERAL DIRECTOR <i>MAURICE E. NEWMAN & SON, Easton, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>JUL 31 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10109

10119

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY in lb. <u>18 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>102 W. Chestnut St.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>Bessie Baker Caulk</u>		4 DATE OF DEATH Month Day Year <u>7 1 1967</u>	
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>JUN 28, 1888</u>
9 AGE (In years last birthday) <u>79</u>		10a. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired) <u>HOUSEWIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11 BIRTHPLACE (County & State, or foreign country) <u>SOMERSET Co., MD</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES B. BAKER</u>	
14 MOTHER'S MAIDEN NAME <u>CLARA ROTH</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16 SOCIAL SECURITY NO. <u>216-46-4128</u>		17 INFORMANT <u>MRS. R.J. ALLEN, RD 1, BOX 384, EASTON, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertensive & other vascular</u> DUE TO (c) <u>Cerebro Vascular</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 hrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> , 19 to <u>7-1-67</u> , that (I) (we) last saw the deceased alive on <u>7-1-67</u> , and that death occurred at <u>2nd</u> M, from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u>		22b DATE SIGNED <u>7-3-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Dr. M. Beeter & mid</u>		22d ADDRESS <u>St. Michaels mid</u>	
23a BURIAL (CREMATION) REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>JUL 5, 1967</u>	
23c NAME OF CEMETERY OR CREMATORY <u>OLIVET CEMETERY</u>		23d LOCATION (City or Town) (County) (State) <u>ST. MICHAELS, MD</u>	
24 FUNERAL DIRECTOR <u>Danison E. Leonard, St. Michaels, Md.</u>		25a REC'D BY REGISTRAR <u>[Signature]</u> 25b REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2c & d Film #3490 7/13/67 pc

10110

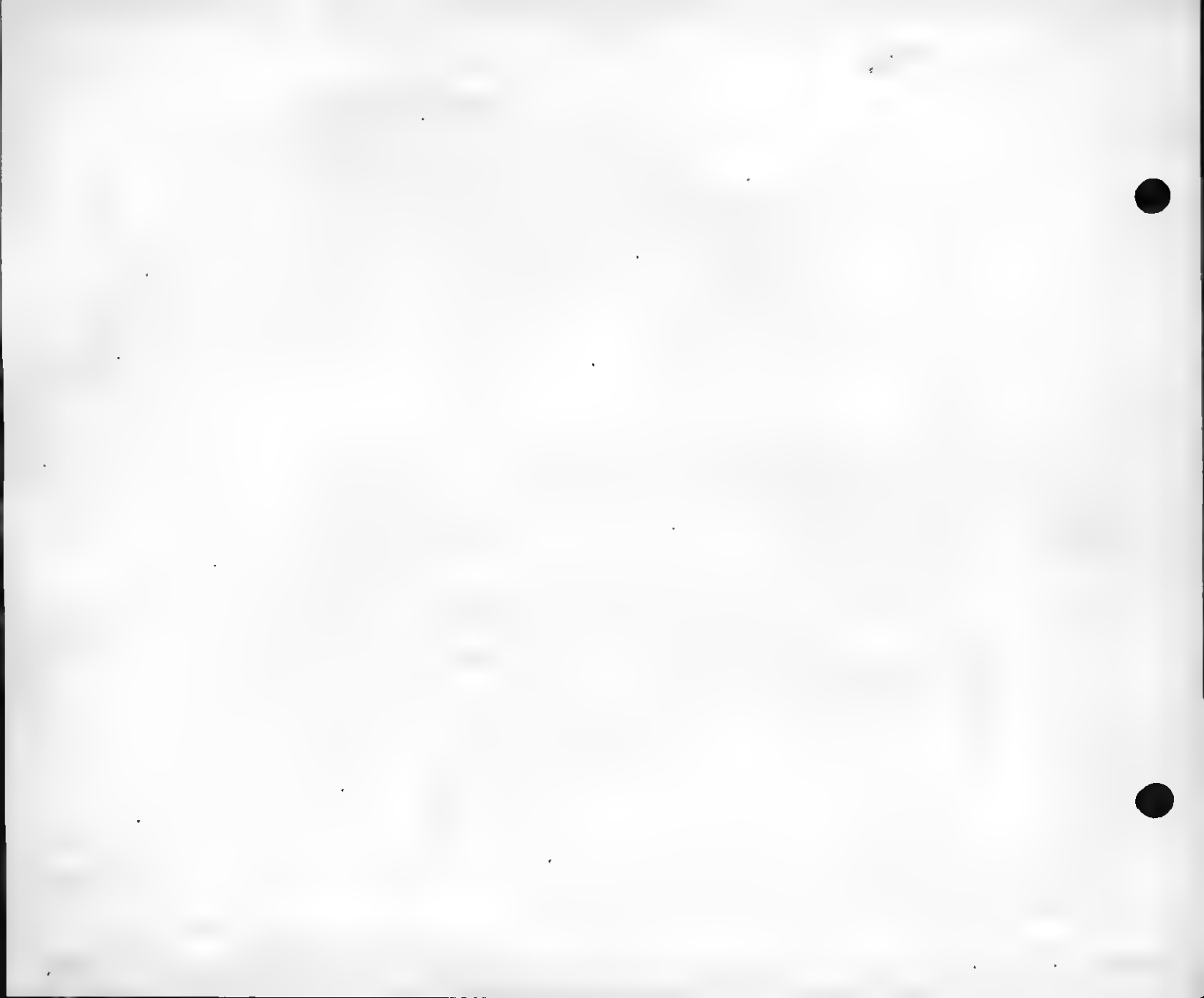
CERTIFICATE OF DEATH

10113

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural St Michael</u> c. LENGTH OF STAY IN lb <u>3 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NO VISTA NURSING HOME</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural St Michael</u> d. STREET ADDRESS <u>9 Plum Street</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>MARTHA TRUITT CLARK</u> First Middle Last 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>JULY 6 1967</u> Month Day Year 5. AGE (In years last birthday) <u>88</u> If UNDER 1 YEAR Months Days Hours Min If UNDER 24 HRS Months Days Hours Min 6. DATE OF BIRTH <u>SEPT. 7 1878</u> 7. BIRTHPLACE (County & State or foreign country) <u>OCEAN VIEW, DELE</u> 8. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> 11. FATHER'S NAME <u>JAMES T. BETTS</u> 12. MOTHER'S MAIDEN NAME <u>MARTHA WILLIAMS</u>		13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 14. SOCIAL SECURITY NO. <u>73-12-99970</u> 15. INFORMANT <u>HAZEL T. CLARK EASTON, MD</u> Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334x</u> <u>cachexia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>atherosclerotic cerebrovascul</u> DUE TO (c) <u>cardiovascular changes</u>		INTERVAL BETWEEN ONSET AND DEATH <u>none</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-22-1967</u> to <u>7-6-1967</u> , that (I) (we) last saw the deceased alive on <u>7-4-67</u> 19 <u>67</u> , and that death occurred <u>10:25 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Wm M. Reeser</u> 22c. PHYSICIAN'S NAME (Type) <u>Wm M. Reeser</u>		22b. DATE SIGNED <u>7-7-67</u> 22d. ADDRESS <u>St. Michael's Ind.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 9, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Benton</u>		23d. LOCATION (City or Town) (County) (State) <u>Benton Calver, Md</u>	
24. FUNERAL DIRECTOR <u>Rollis Clark</u> ADDRESS <u>Easton, Md</u>		25a. REC'D. BY REGISTRAR <u>JUL 10 1967</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

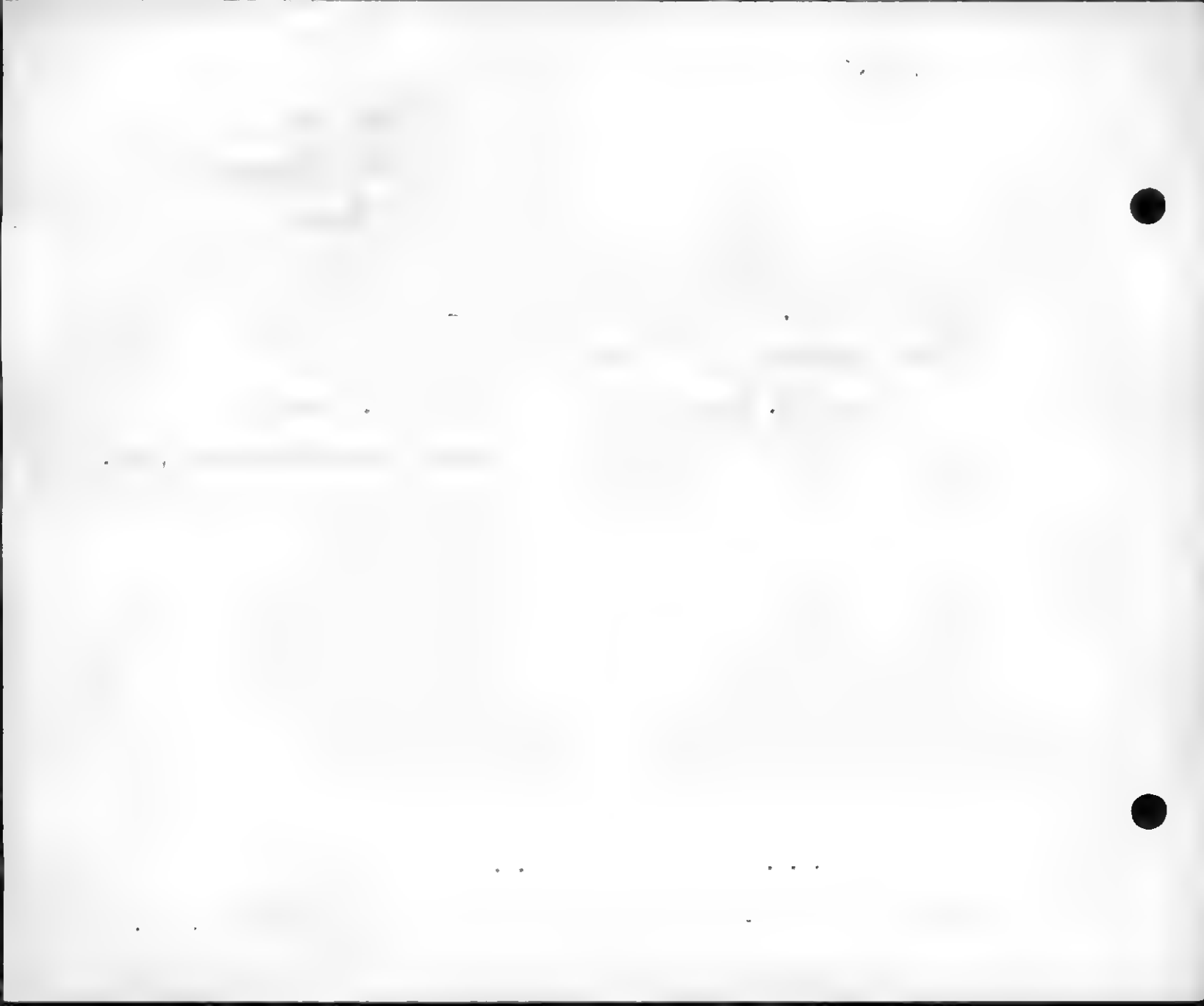
10111

CERTIFICATE OF DEATH

10111

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN TB <u>11 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greensboro</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>None</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Silas</u> Middle <u>-</u> Last <u>Cooper</u>		4. DATE OF DEATH Month <u>7</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-5-1902</u>
9. AGE (In years last birthday) <u>64</u> yrs		10. USUAL OCCUPATION (Give kind of work done during last week of life) <u>Farm Laborer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-34-3535</u>	
17. INFORMANT <u>Paul Cooper Greensboro, Md.</u>		Address	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac insufficiency</u> <u>4222</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ruptured ulcer closed 7/5/67</u>		INTERVA. BETWEEN ONSET AND DEATH <u>48 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/5</u> , 19 <u>67</u> to <u>7/16</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/16</u> , 19 <u>67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. T. B. Ambler</u>		22b. DATE SIGNED <u>7/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. T. B. Ambler</u>		22d. ADDRESS <u>M. D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	23d. LOCATION (City or Town) (County) (State) <u>Goldsboro, Md.</u>
24. FUNERAL DIRECTOR <u>L. E. Boucous</u>		25a. REC'D BY REG. STRAR <u>JUL 20 1967</u>	
ADDRESS <u>Greensboro, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

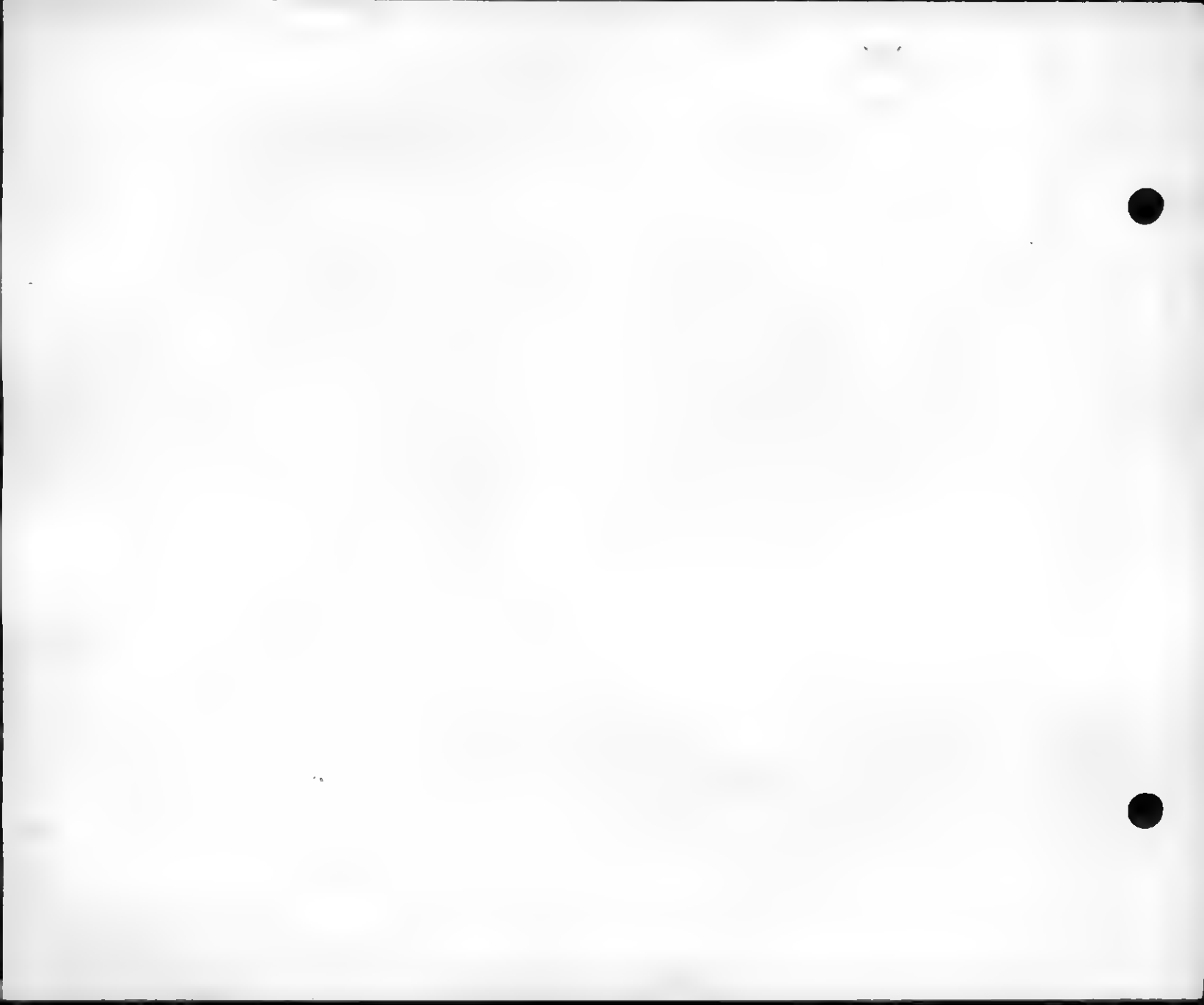
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10112

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> c. LENGTH OF STAY IN 1b <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>McMichael</u>				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL QUEENSTOWN</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>Collington</u> Last <u>Collington</u> 4 DATE OF DEATH Month <u>July</u> Day <u>14</u> Year <u>1967</u> 5 SEX <u>F</u> 6 COLOR OR RACE <u>W</u> 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8 DATE OF BIRTH <u>SEPT. 12, 1924</u> 9 AGE (In years, most birthday) <u>42</u> yrs 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u> 10b KIND OF BUSINESS OR INDUSTRY _____ 11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>JOHN CARROLL</u> 14. MOTHER'S MAIDEN NAME <u>STELLA MARY CARROLL</u> 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> 16 SOCIAL SECURITY NO _____ 17 INFORMANT <u>WESLEY COVINGTON</u> Address <u>QUEENSTOWN</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> DUE TO (b) <u>Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 20c TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. <u>19</u> 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f (City or town) (County) (State) _____ 21. I certify that (If this hospital attended the deceased from _____, 19____ to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>2:07 AM</u> , from causes and on the date stated above. 22a SIGNATURE <u>E.C.H. Schmidt</u> 22b DATE SIGNED <u>7-14-67</u> 22c PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u> 22d ADDRESS <u>Easton, Md.</u> 23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b DATE THEREOF <u>July 17, 1967</u> 23c NAME OF CEMETERY OR CREMATORY <u>CHESTERFIELD</u> 23d LOCATION (City or Town) (County) (State) <u>CENTREVILLE MD.</u> 24 FUNERAL DIRECTOR <u>Home Funeral Home Center Inc.</u> 25a REC'D BY REGISTRAR <u>JUL 19 1967</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

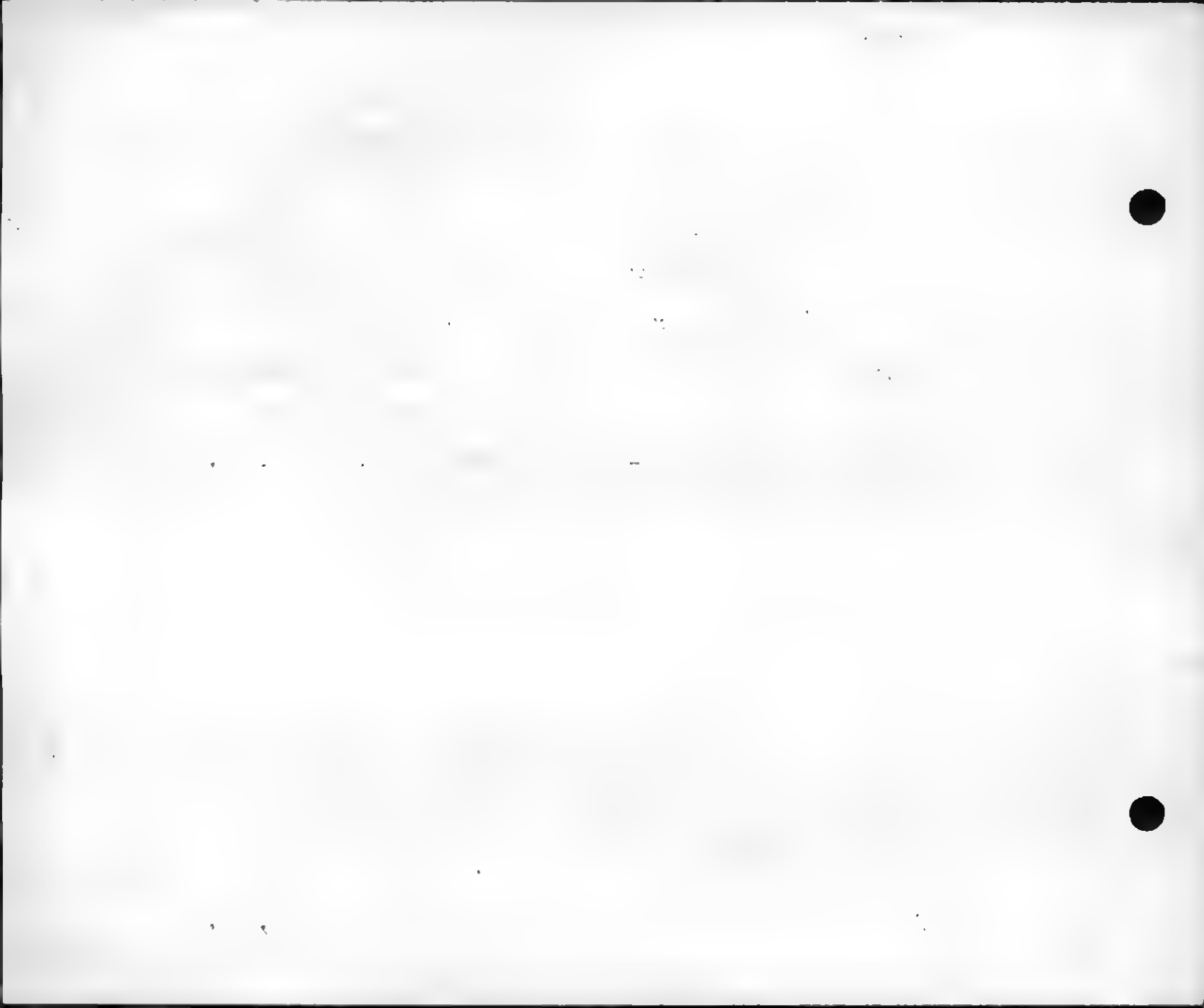
101113

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

101113

1. PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Talbot</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN 1b <u>2 1/2 wks</u>	
c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Oxford</u>		d STREET ADDRESS	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Columbus</u> Last <u>Cox</u>		4. DATE OF DEATH Month <u>7</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/1882</u>
9. AGE (in years birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Dorchester Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Cox</u>		14. MOTHER'S MAIDEN NAME <u>Anna May Hobbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>215-16-3532</u>	
17. INFORMANT <u>Clarence Cox, Oxford, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332A DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bladder Carcinoma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/26</u> , 19 <u>67</u> , to <u>7/13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/13</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> P.M., from causes and on the date stated above			
21a. SIGNATURE <u>Robert M. McDonald</u>		21b. DATE SIGNED <u>7/13/67</u>	
22. PHYSICIAN'S NAME (Type) <u>Robert McDonald</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/15/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u>		23d. LOCATION (City or town) (County) (State) <u>Oxford, Md.</u>	
24. FUNERAL DIRECTOR <u>Maxwell E. Williams</u>		25a. REC'D BY REGISTRAR <u>James J. Jones</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE <u>JUL 18 1967</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

1 DOA 10/10pm
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
ITEM 18 Film 391 7-27-67 ams Item 1188 Film 391 7-31-67 ams
10114
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE M.D. b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN TB D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) THE STRANAHAN Memorial Hospital				d. STREET ADDRESS TRED AVON APTS.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle S. Last EMANUEL				4. DATE OF DEATH Month 7 Day 3 Year 1967			
5. SEX fe		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB 14, 1905	
9. AGE (In years last birthday) 62 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEKEEPER		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD	
13. FATHER'S NAME JOHN FROMMILLER				14. MOTHER'S MAIDEN NAME MARTHA B. STRAYER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO 155-86-3667		17. INFORMANT HENDERSON EMANUEL Address OXFORD, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.9 DUE TO (b) Drowning Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) --			
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Talbot	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Lewis O. Welty EXAMINER'S NAME (Type) WELTY				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) MD			
22. DATE SIGNED 7-4-67							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF JULY 6, 1967		23c. NAME OF CEMETERY OR CREMATORY OXFORD		23d. LOCATION (City or Town) (County) (State) OXFORD TALBOT MD	
24. FUNERAL DIRECTOR Robert B. ...				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10115

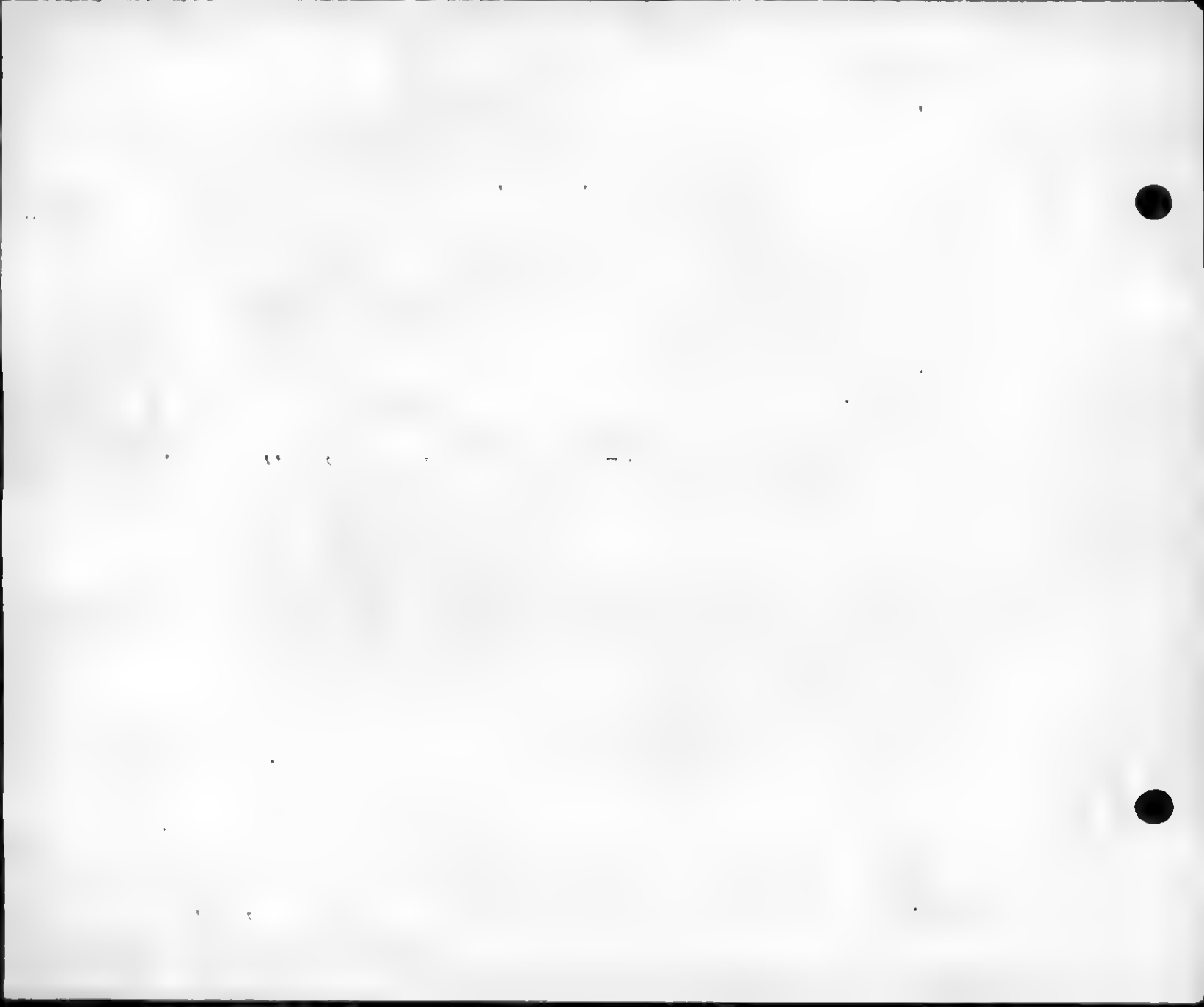
CERTIFICATE OF DEATH

10115

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY IN 1b 2 yrs. 7 mo.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HOUSE IN THE PINES EASTON		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last LELIA ESSICK		4 DATE OF DEATH Month Day Year 7 31 1967	
5 SEX female	6 COLOR OR RACE white	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 5/8/1893
9a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		9b KIND OF BUSINESS OR INDUSTRY	
10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Talbot Maryland		12 CITIZENSHIP OF WHAT COUNTRY USA	
13 FATHER'S NAME Isaac Elliott		14 MOTHER'S MAIDEN NAME Augusta Goslin	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO 215-48-7451	
17 INFORMANT Melvin R. Essick, Sr., Easton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Atherosclerotic Cardiovascular Dis. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11:23 , 19 67 to 7:31 , 19 67 that (I) (we) last saw the deceased alive on 7/20 19 67 and that death occurred at 5:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE S. Krech		22b. DATE SIGNED 7.31.67	
22c. PHYSICIAN'S NAME (Type) S. Krech JR		22d. ADDRESS Easton	
23a BURIAL, CREMATION, or MOVING (Specify)	23b. DATE THEREOF 8/3/1967	23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery	23d. LOCATION (City or town) (County) (State) Mardela, Md.
24. FUNERAL DIRECTOR Maurice E. Newman + Son Easton Md.		25a REC'D BY REGISTRAR Aug 1 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

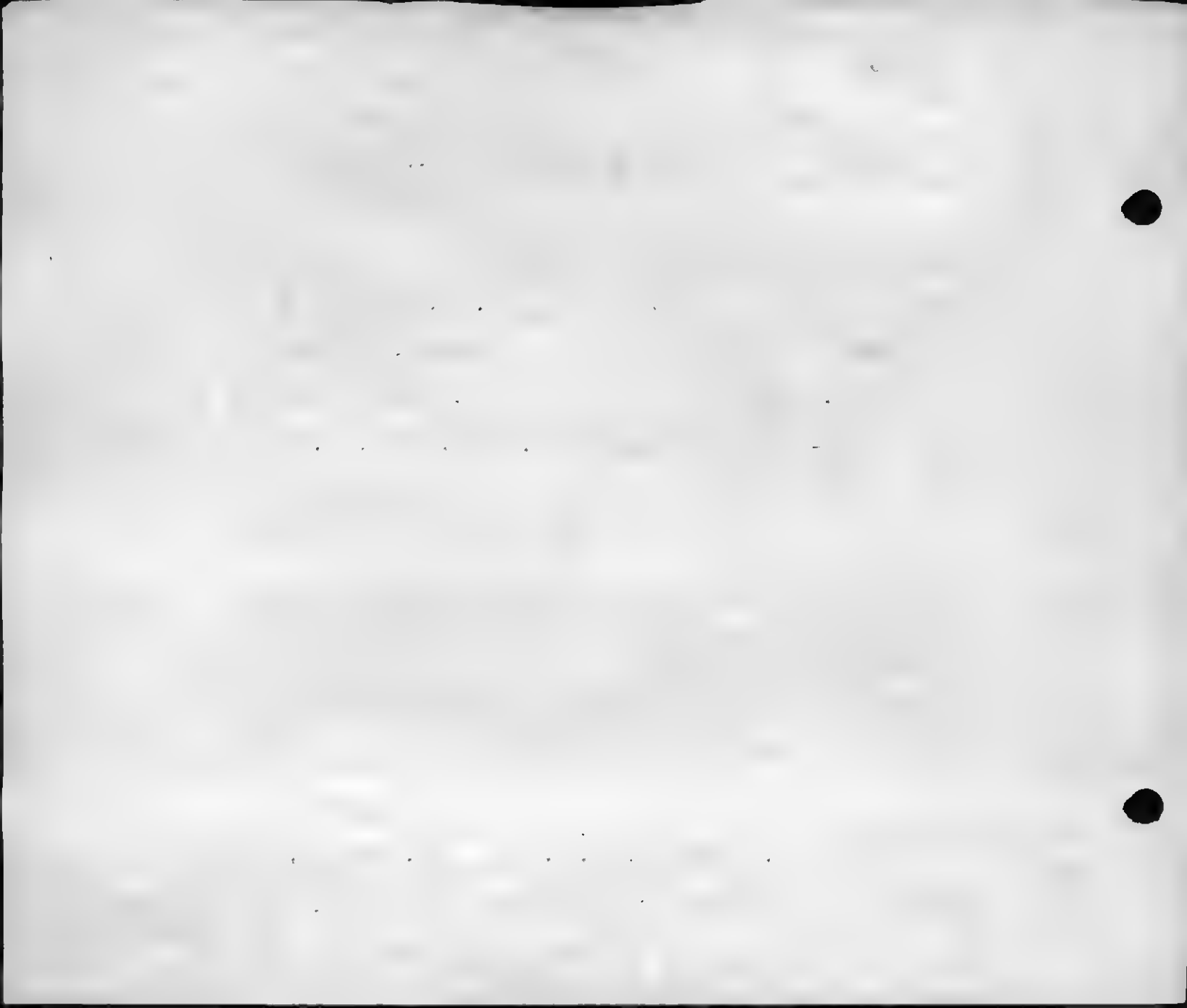
10116

CERTIFICATE OF DEATH

10119

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bozman c. LENGTH OF STAY IN IL 3 wks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) -----				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels d. STREET ADDRESS Maple Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH RUBERT EVANS				4. DATE OF DEATH Month Day Year July 1, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Dec. 25, 1889		9. AGE (In years last birthday) 77 yrs. <div style="display: flex; justify-content: space-between;"> IF UNDER 1 YEAR IF UNDER 24 HRS. </div>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner			
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Roanoke, Virginia		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John S. Evans				14. MOTHER'S MAIDEN NAME A. Elizabeth Slinning			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 03 0358		17. INFORMANT J. Taylor Evans, St. Michaels, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia DUE TO Bronchiogenic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO carcinoma (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 to 1 July 1967 , that (I) (we) last saw the deceased alive on 1 July 1967 , and that death occurred at 2 AM , from the causes and on the date stated above.							
22a. SIGNATURE GUY M. REESER, Jr., M.D.				22b. DATE SIGNED 2-3-67			
22c. PHYSICIAN'S NAME (Type) GUY M. REESER, Jr., M.D.				22d. ADDRESS St. Michaels, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 3, 1967		23c. NAME OF CEMETERY OR CREMATORY Olivet Cemetery			
23d. LOCATION (City, town or county) St. Michaels, Maryland		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE Harrison E. Leonard, St. Michaels, Md.				25a. REC'D BY REGISTRAR JUL 6 1967			
25b. REGISTRAR'S SIGNATURE Charles Judge				DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

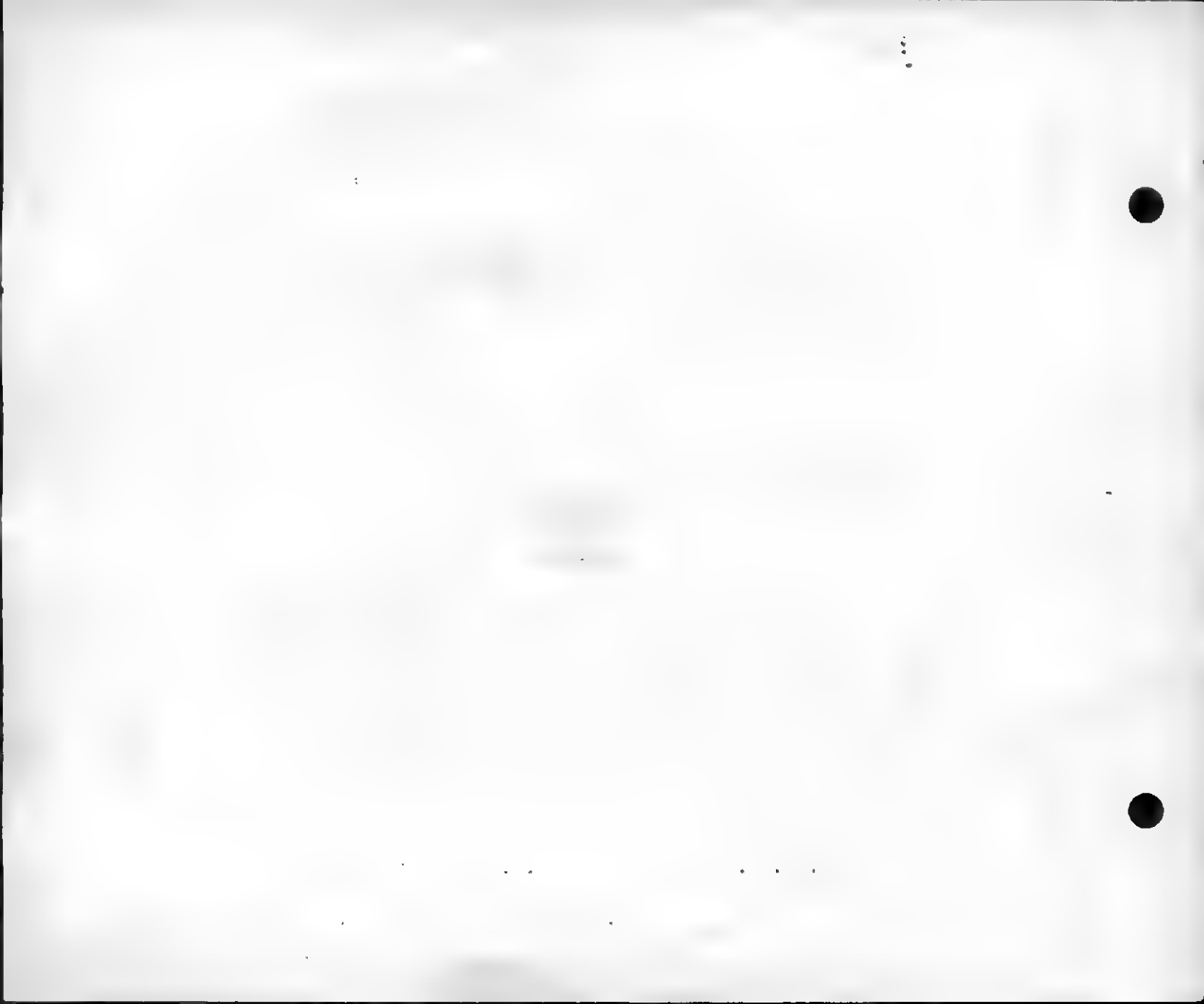
10117

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10120

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marydel, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Ada Patricia Fletcher</u>				4. DATE OF DEATH <u>7</u> Month <u>17</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/1921</u>	9. AGE (In years last birthday) <u>46</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>			10b. KIND OF BUSINESS OR IND. STRY <u>Various</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>—</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>YES</u>		17. INFORMANT <u>MRS. Lois Murray</u> Address <u>MARYDEL, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of abdominal</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of cervix</u> DUE TO (c) <u>—</u>							INTERVA. BETWEEN ONSET AND DEATH <u>June 66</u> <u>May '66</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of Item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/13/67</u> to <u>7/17</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/16</u> 19 <u>67</u> , and that death occurred at <u>7⁴⁵</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>J. T. B. Ambler</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. T. B. Ambler</u> M.D.				22d. ADDRESS <u>Easton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/22/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist Cem. Maryland</u>		23d. LOCATION (City or Town) (County) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>Jenneth Walley</u> ADDRESS <u>Chestertown, MD</u>				25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Jenneth Walley</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

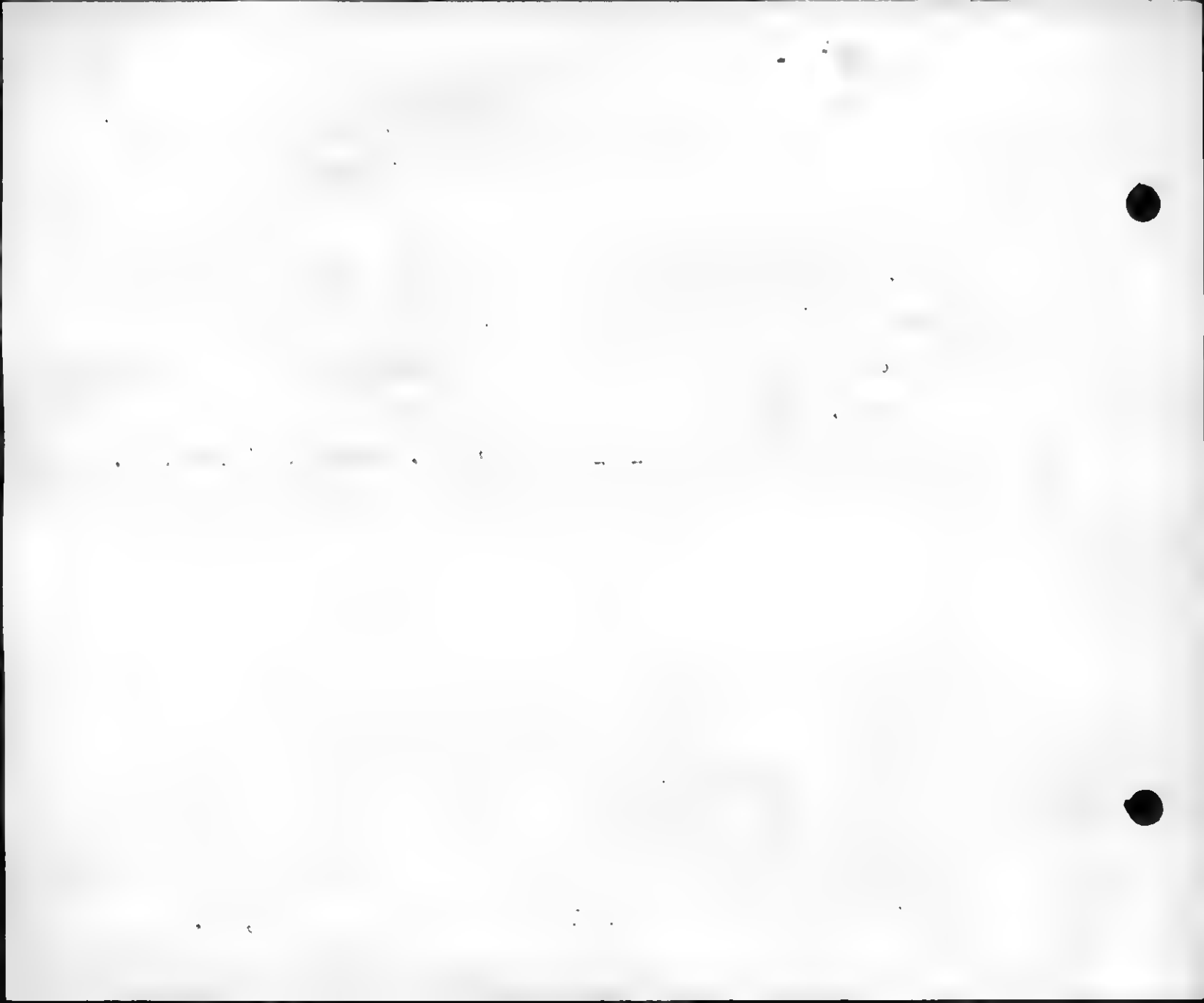
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10118

CERTIFICATE OF DEATH

10121

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE Viola Fluharty</u>		4 DATE OF DEATH Month Day Year <u>July 24 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>10/8/1895</u>
9 AGE (In years last birthday) <u>71</u> yrs		10 IF UNDER 24 HRS Months Days Hours M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Todd</u>		14. MOTHER'S MAIDEN NAME <u>Anna Noskey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-20-2549</u>	
17. INFORMANT <u>Edward D. Fluharty, Talbott, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Intestinal Obstruction</u> DUE TO (b) <u>Adhesive fibrous band</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVA. BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/24/19</u> to <u>7/24/67</u> , that (I) (we) last saw the deceased alive on <u>7/24/67</u> and that death occurred at <u>1:24</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>E. C. H. Schmitt</u>		22b. DATE SIGNED <u>24 July 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. C. H. Schmitt</u>		22d. ADDRESS <u>Easton, Md 21601</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/26/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Landing Neck</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>
24. FUNERAL DIRECTOR <u>Maurice E. Newman & Son</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

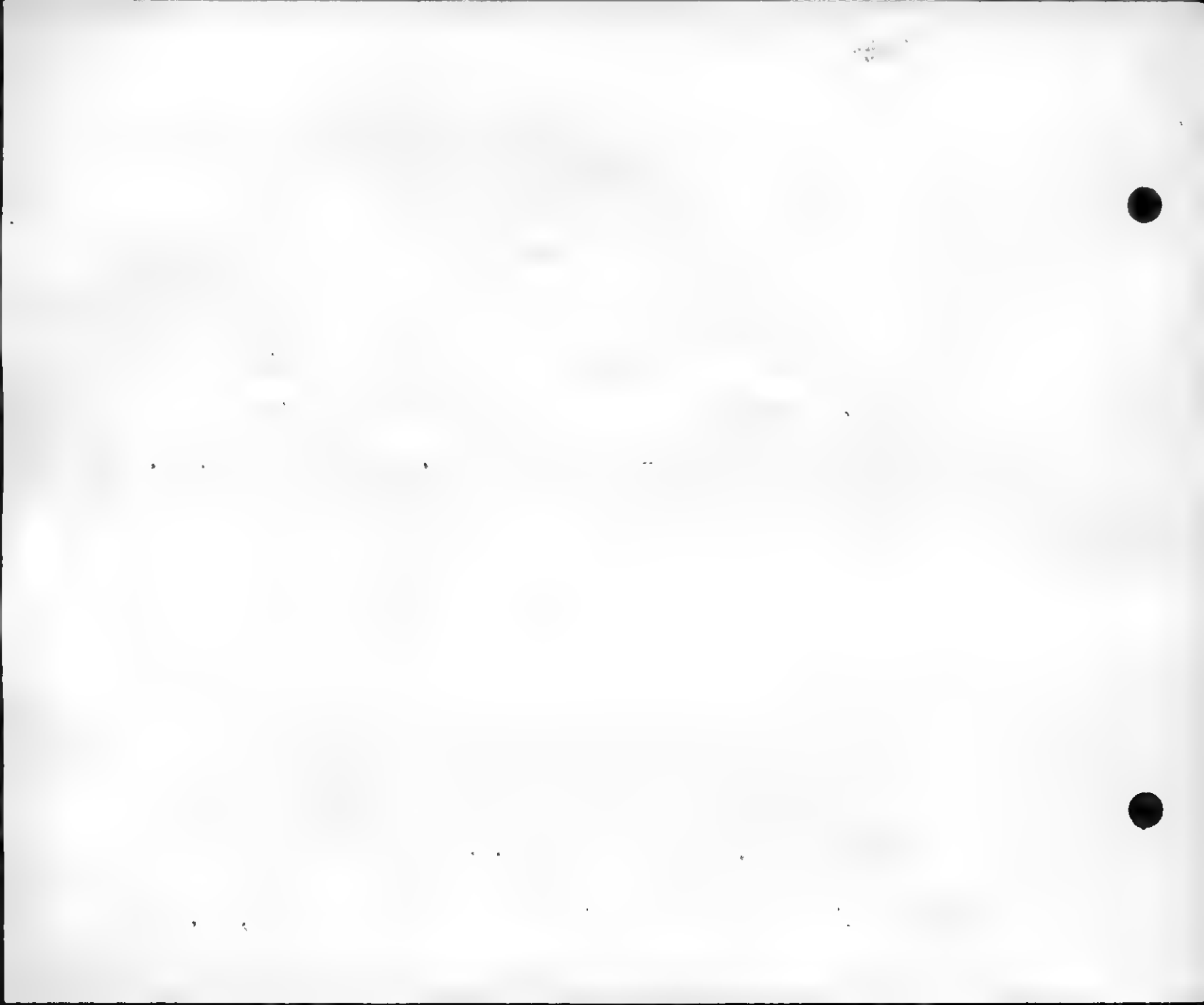
10119

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10122

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>13 hrs. 50 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bennett</u> Middle <u>SULLIVAN</u> Last <u>FRAMPTON</u>				4. DATE OF DEATH Month <u>July</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/22/1898</u>	9. AGE (In years last birthday) <u>68</u> yrs	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. UNDER 24 HRS Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory worker</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Canning</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>James A. Frampton</u>				
14. MOTHER'S MAIDEN NAME <u>Katie Mae Sullivan</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				
16. SOCIAL SECURITY NO <u>218-20-4133</u>			17. INFORMANT <u>James C. Frampton, Easton, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Progressive arteriosclerotic Parkinson's Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7-30</u> , 19 <u>67</u> , to <u>7-31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-30</u> 19 <u>67</u> , and that death occurred at <u>12:30</u> AM, from causes and on the date stated above.							
22a. SIGNATURE <u>Stephen P. Carney</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>7-31-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>		M.D. 22d. ADDRESS <u>Easton, Maryland</u>	7/31/67				
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Inter Burial</u>	23b. DATE THEREOF <u>8/2/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>	23d. LOCATION (City or Town) (County) (State) <u>Easton, Md.</u>				
24. FUNERAL DIRECTOR <u>Marvise E. Newman Son Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>James C. Judge</u>				



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10120

CERTIFICATE OF DEATH

10123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD</u> b COUNTY <u>Dorchester</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c LENGTH OF STAY IN 16 <u>12 d.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Richard W. GRACIE</u>		4 DATE OF DEATH <u>7 15 1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/17/1899</u>
9 AGE (In years last birthday) <u>68</u> yrs		10 UNDER 1 YEAR <u>15</u> Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Steamship Clerk</u>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>James Gracie</u>		14 MOTHER'S MAIDEN NAME <u>Margaret Jeffares</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	
17 INFORMANT <u>Mrs. Richard Gracie</u> Address <u>Rhodesdale</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Acute myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (b) <u>12 day</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (th s hospital) attended the deceased from <u>1 July 1967</u> to <u>13 July 1967</u> , that (I) (we) last saw the deceased alive on <u>7-13</u> 19 <u>67</u> and that death occurred at <u>12</u> M, from causes arid on the date stated above.			
22a SIGNATURE <u>Stephen P. Carney</u> M.D.		22b DATE SIGNED <u>7-13-67</u>	
22c PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>		22d ADDRESS <u>Easton, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7/15/67</u>	
23c NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		23d LOCATION (City or Town) (County) (State) <u>East New Market Md</u>	
24. FUNERAL DIRECTOR <u>John S. Miloughy</u> ADDRESS <u>East New Market</u>		25a REC'D BY REGISTRAR <u>JUL 27 1967</u> DATE	
		25b REGISTRAR'S SIGNATURE <u>John S. Miloughy</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1558

10121

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please complete carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

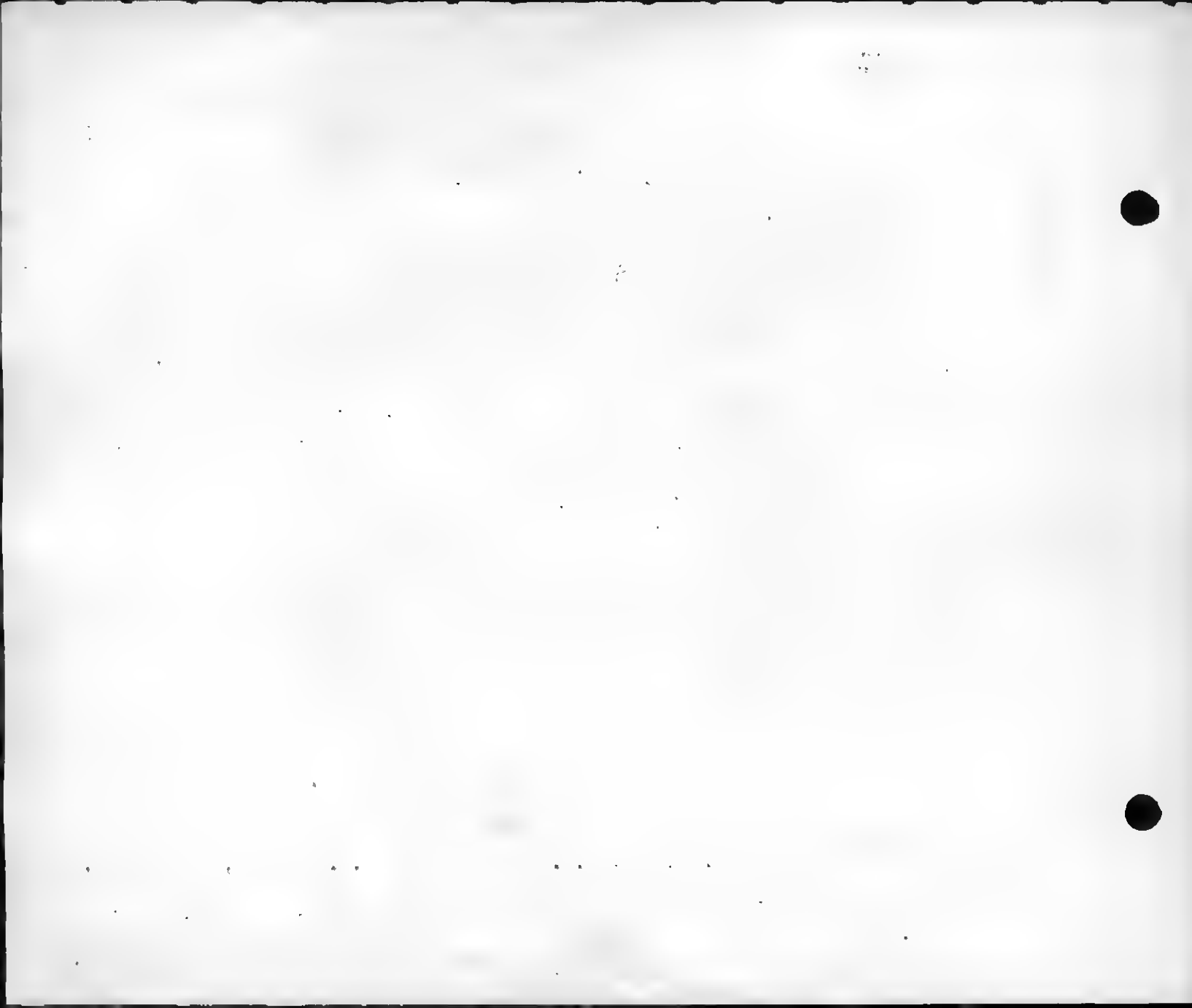
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN b. <u>1 hr 25 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Bay</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>7</u> Day <u>- 30</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-67</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Easton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Not given by mother</u>		14. MOTHER'S MAIDEN NAME <u>Shirley Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Memorial Hospital, E.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> 776x DUE TO Condition, <u>ay</u> , which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/30/67</u> to <u>8/1/67</u> , that (I) (we) last saw the deceased alive on <u>3:31 AM</u> 19 <u>67</u> , and that death occurred at <u>4:05 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Justin T. Callahan</u> M.D.		22b. DATE SIGNED <u>8/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Justin T. Callahan</u>		22d. ADDRESS <u>11 Bayview Easton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>August 1, 1967</u>	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY <u>Bridgetown</u>	23d. LOCATION (City or Town) (County) (State) <u>Bridgetown Caroline Md.</u>
24. FUNERAL DIRECTOR <u>Callahan 412-5451</u>		25a. REC'D BY REGISTRAR <u>AUG 11 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10122 CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) EASTON			c. LENGTH OF STAY IN 1b mons20 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) OXFORD			d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 10 HOUSE IN THE PINES - EASTON					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Salvo			First Middle Last A. Lassiter		4. DATE OF DEATH July 17 19 67		Month Day Year		
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-3-1874		9. AGE (in years last birthday) 93 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED			10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) PETERSBURG-VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ROBERT P. HAMILTON					14. MOTHER'S MAIDEN NAME LELIA WATKINS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 217-44-1948		17. INFORMANT MRS. ALFRED S. NALLE		Address OXFORD, MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Progressive arteriosclerosis 4300 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO (c) _____									INTERVAL BETWEEN ONSET AND DEATH 1 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. _____ p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from now , 19 66 , to 7-17 , 19 67 , that (I) (we) last saw the deceased alive on 7-17 , 19 67 , and that death occurred 8:30 P.M. the causes and on the date stated above.									
22a. SIGNATURE Stephen P. Carney					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-18-67		
22c. PHYSICIAN'S NAME (Type) Stephen P. Carney, M.D.					22d. ADDRESS P.O. Box 929, Easton, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF JULY 20, 1967		23c. NAME OF CEMETERY OR CREMATORY OLD BLANDFORD CEMETERY		23d. LOCATION (City, town or county) (State) PETERSBURG - VA.			
24. FUNERAL DIRECTOR Charles Judge					25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge		
DATE JUL 19 1967									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10123

CERTIFICATE OF DEATH

20125

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u>		2. USUAL RESIDENCE (Where deceased lived, first institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN 1b <u>10 dA.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp. Tal</u>		d. STREET ADDRESS <u>THE STRAND</u>	
3. NAME OF DECEASED (Type or print) First <u>Edith L.</u> Middle <u>PARSONS</u> Last <u>LEEPER</u>		4. DATE OF DEATH Month <u>7</u> Day <u>27</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-1889</u>
9. AGE (in years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRACTICAL NUR</u>	
11. BIRTHPLACE (County & State or foreign country) <u>SHELDON, VERNON, MO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD PARSONS</u>		14. MOTHER'S MAIDEN NAME <u>HARRIETT ALICE MOREHOUSE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>363-34-057X</u>	
17. INFORMANT <u>MRS MAURINE PARKER</u>		Address <u>OXFORD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X</u> DUE TO <u>Chronic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatous</u> DUE TO <u>Rectal Carcinoma</u> (c) <u>Rectal Carcinoma</u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>8:25</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert McDonald</u> M.D.		ATTENDING PHYS <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>7/28/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Robert McDonald</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8-3-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SHELDON</u>	23d. LOCATION (City or Town) (County) (State) <u>SHELDON, VERNON MO.</u>
24. FUNERAL DIRECTOR <u>Robert McDonald</u>		25a. RECEIVED BY REGISTRAR <u>JUL 31 1967</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. This may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

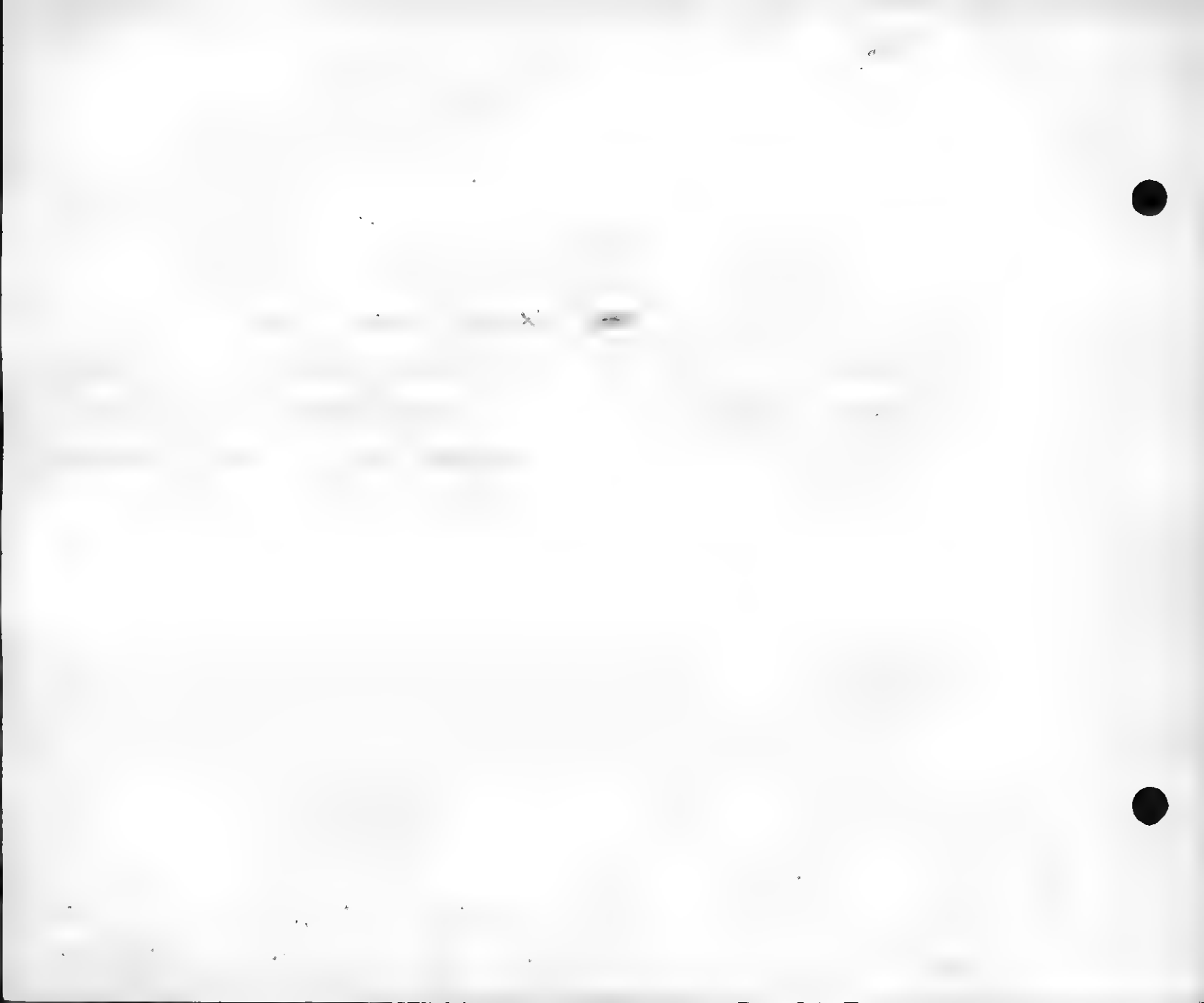
10124

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DOH 615
10:28 AM

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. STATE <u>MD.</u> c. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. LENGTH OF STAY IN TB _____	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>		d. STREET ADDRESS <u>1315 HENRIETTA AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>LUDIE</u> First <u>WILLIE</u> Middle <u>LILLY</u> Last		4. DATE OF DEATH <u>7</u> Month <u>30</u> Day <u>1967</u> Year	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>12-9-1926</u>
9. AGE (In years, last birthday) <u>40</u> yrs		10. IF UNDER 1 YEAR: Months _____ Days _____	
11. IF UNDER 24 HRS: Hours _____ Min _____			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>COOK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAFETERIA</u>	
11. BIRTHPLACE (State or foreign country) <u>Wadesboro, N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Lilly</u>		14. MOTHER'S MAIDEN NAME <u>Willie Mae Ramsey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>216-01-0490</u>	
17. INFORMANT <u>Mrs. Naomi Rogers</u> Address <u>2702 Liberty Hgts</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Drowning</u> 7399 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS A Topsy PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work _____	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Jacques R. Caldwell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Jacques R. Caldwell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-4-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l Cem.</u>		23d. LOCATION (City or Town) <u>Balto.</u> (County) _____ (State) <u>MD.</u>	
24. FUNERAL DIRECTOR <u>MORON Dye H. H.</u> ADDRESS <u>1701 Laurens St.</u>		25a. REC'D BY REGISTRAR <u>DAMUG</u> 3 1967	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10125

CERTIFICATE OF DEATH

10127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, f institution Residence before adm ssion) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write BURIAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN <u>5 days.</u>		c. CITY OR TOWN (If ads de corporate limits, write BURIAL and give nearest town) <u>RIC VISTA TERRACE - ST MICHAELS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Virginia</u> Last <u>Lutz</u>				4. DATE OF DEATH Month <u>7</u> Day <u>15</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1918</u>	9. AGE (In years last birthday) <u>49</u> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of workng life, even if retired) <u>HOUSEKEEPER MARGANT - OWN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TALBOT-MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>THOMAS SAMUEL GAY</u>				14. MOTHER'S MAIDEN NAME <u>BERTHA ELLEN PATRICK</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		SOCIAL SECURITY NO <u>713-039471</u>		17. INFORMANT <u>WILLIAM LUTZ ST MICHAELS</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ca chedria</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinomatosis-generalized</u> DUE TO (c) <u>ca Breast</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 to <u>7-15-1967</u> , that (I) (we) last saw the deceased alive on <u>7-15-1967</u> and that death occurred at <u>7:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Wm M Reeser</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>7-15-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm M Reeser</u>				22d. ADDRESS <u>St Michaels</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>		23d. LOCATION (City or Town) (County) (State) <u>EASTON TAL. MD</u>	
24. FUNERAL DIRECTOR <u>Ellie Clark</u>				ADDRESS <u>Easton Md</u>		25a. REC'D BY REGISTRAR <u>JUL 17 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

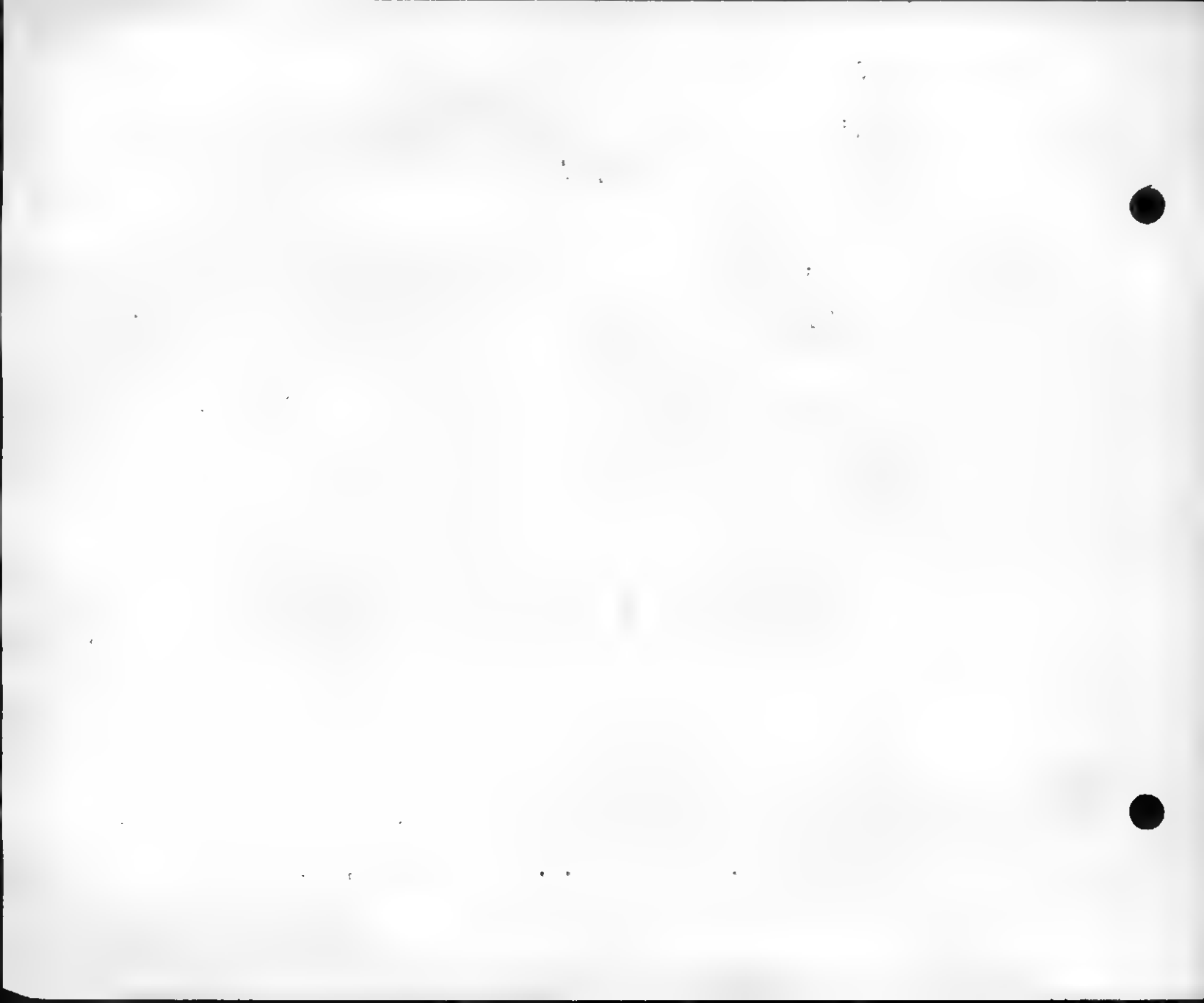
CERTIFICATE OF DEATH

11560

10126

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Talbot MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE 208 SOUTH ST. b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton		c. LENGTH OF STAY IN 1b 14 1/2 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hosp		d. STREET ADDRESS EASTON	
3 NAME OF DECEASED (Type or print) First Baby Middle Boy Last Maldonado		4. DATE OF DEATH Month 7 Day 20 Year 1967	
5 SEX Male	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 7-19-67
9 AGE (In years last birthday) 1		10 IF UNDER YEAR Months 1 Days 1 Hours 1 Min 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) TALBOT - Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EUGENE MALDONADO		14. MOTHER'S MAIDEN NAME DELORES WARNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT DELORES MALDONADO		Address 208 SOUTH ST. EASTON, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 16 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/19 , 19 67 to 7/20 , 19 67 that (I) (we) last saw the deceased alive on 7/19 , 19 67 , and that death occurred at 3:45 AM , from causes and on the date stated above.			
22a. SIGNATURE Justin T. Callahan		22b. DATE SIGNED 7-28-67	
22c. PHYSICIAN'S NAME (Type) Justin T. Callahan, M.D.		22d. ADDRESS Easton, Maryland	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial	23b. DATE THEREOF 7-24-67	23c. NAME OF CEMETERY OR CREMATORY Coppersville	23d. LOCATION (City or town) (County) (State) Coppersville Talbot Md.
24. FUNERAL DIRECTOR Henry H. Dashiell		25a. REC'D BY REGISTRAR DATE AUG 14 1967	
		25b. REGISTRAR'S SIGNATURE James Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

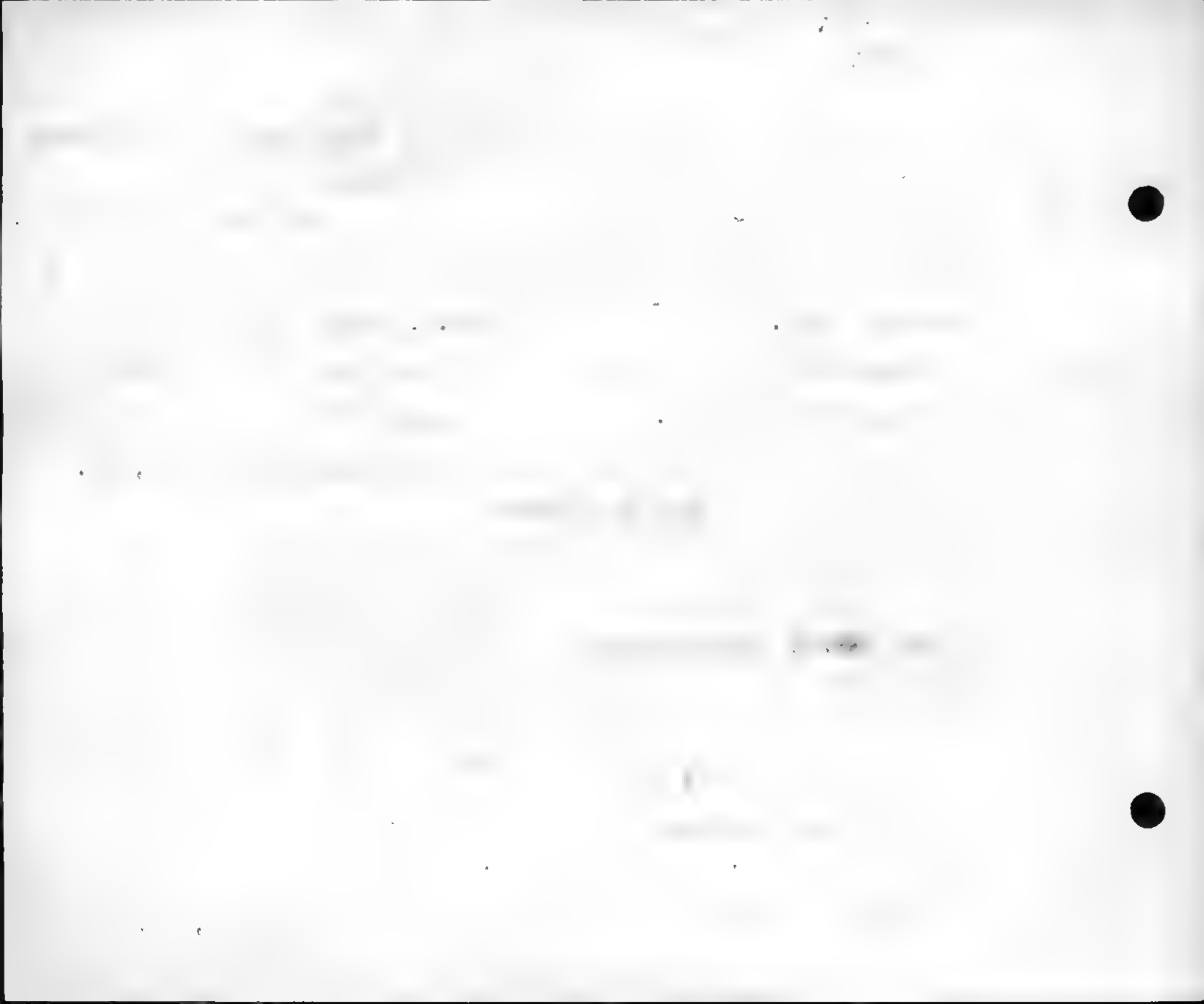
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10127

CERTIFICATE OF DEATH

10123

1 PLACE OF DEATH a COUNTY <u>Talbot</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c LENGTH OF STAY in 1b <u>2 wks</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp. Tal</u>				d STREET ADDRESS <u>Gay Street</u>			
3 NAME OF DECEASED (Type or print) First <u>Genevieve</u> Middle <u>Matilda</u> Last <u>Nichols</u>				4 DATE OF DEATH Month <u>7</u> Day <u>7</u> Year <u>1967</u>			
5 SEX <u>Female</u>	6 COLOR OR RACE <u>Col.</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Nov. 8, 1928</u>		9 AGE (In years last birthday) <u>38</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>19</u> Min <u>67</u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY <u>None</u>		11 BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>Guy Patterson Sr.</u>				14 MOTHER'S MAIDEN NAME <u>Leona Black</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>		17 INFORMANT <u>Noble Patterson Greensboro, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure</u> <u>593X</u> DUE TO <u>Cause unknown -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Class C - IV - Chronic Cerebral</u>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-2-</u> , 19 <u>67</u> , to <u>7-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-7</u> , 19 <u>67</u> , and that death occurred at <u>10:50</u> A.M., from causes and on the date stated above							
22a SIGNATURE <u>Thomas J. McGonagle</u>				22b DATE SIGNED <u>7-10-67</u>		22c PHYSICIAN'S NAME (Type) <u>Thomas J. McGonagle</u>	
22d ADDRESS <u>Easton, Maryland</u>		22e ADDRESS <u>Easton, Maryland</u>					
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>7-10-67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Union</u>		23d LOCATION (City or Town) (County) (State) <u>Goldsboro, Md.</u>	
24 FUNERAL DIRECTOR <u>J. E. Boulain Greensboro, Md.</u>				25a REC'D BY REGISTRAR <u>JUL 13 1967</u>		25b REGISTRAR'S SIGNATURE <u>William J. ...</u>	

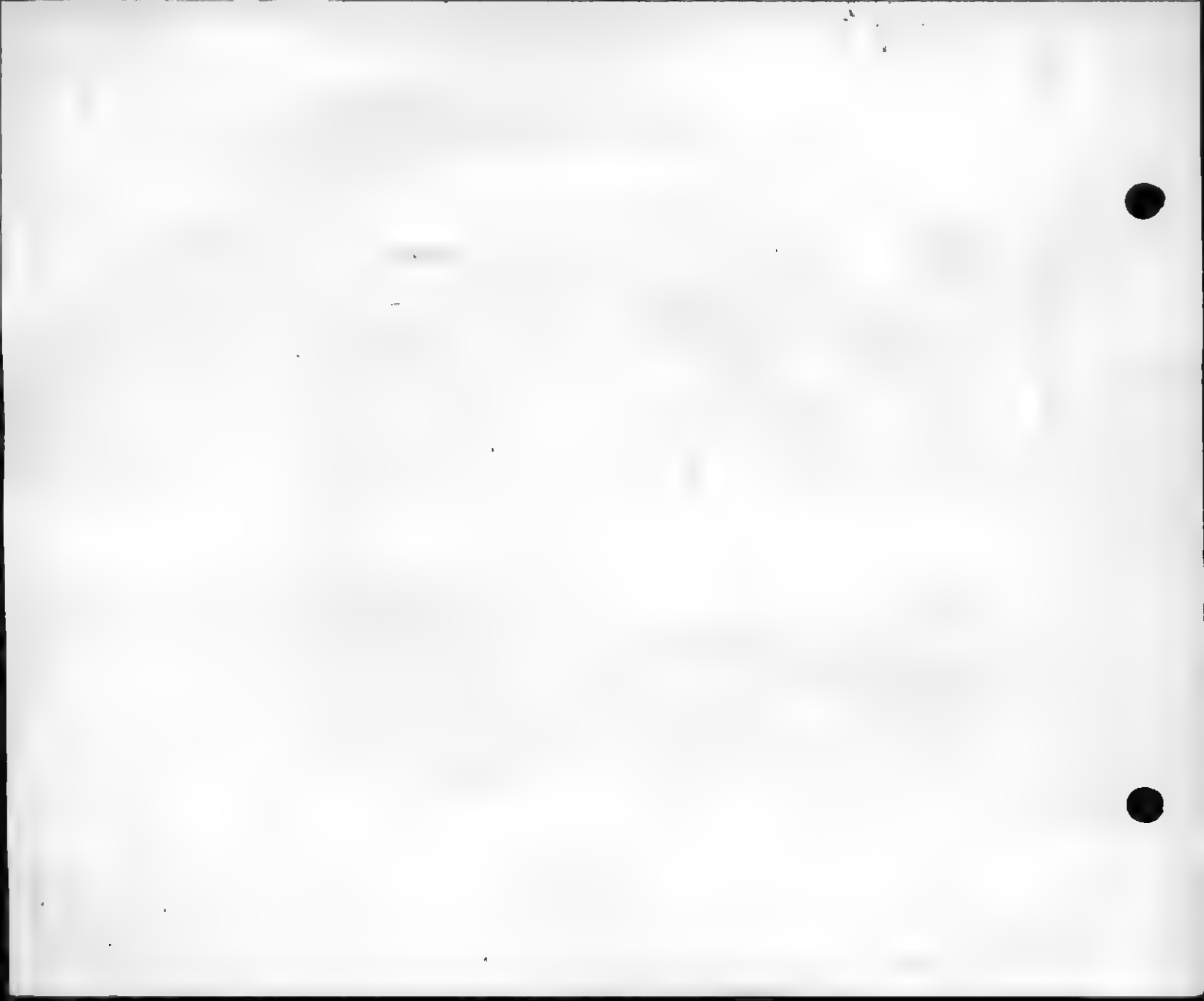


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10128 MARYLAND STATE DEPARTMENT OF HEALTH
BUREAU OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Talbot b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) XXX		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton d. STREET ADDRESS XXX e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Nanie First Mae Middle Palmer Last 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH July Day 2 Year 1967 8. DATE OF BIRTH March 7-1895 9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY XXX		11. BIRTHPLACE (County & State, or foreign country) Stevensville, Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Charles Lane		14. MOTHER'S MAIDEN NAME Rozena Bridges	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Leo Hutchison--Easton, Maryland Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HB DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 62 , to July 2 , 19 67 , that (I) (we) last saw the deceased alive on 11 May , 19 65 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stephen P. Carney		22b. DATE SIGNED 7-3-67	
22c. PHYSICIAN'S NAME (Type) STEPHEN P. CARNEY		22d. ADDRESS EASTON MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 5	
23c. NAME OF CEMETERY OR CREMATORY Stevensville		23d. LOCATION (City, town or county) (State) Stevensville, Maryland	
24. FUNERAL DIRECTOR Edgar L. Lane ADDRESS Church Hill, Md.		25a. REC'D BY REGISTRAR JUL 11 1967 25b. REGISTRAR'S SIGNATURE Merley J. J.	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach ribbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

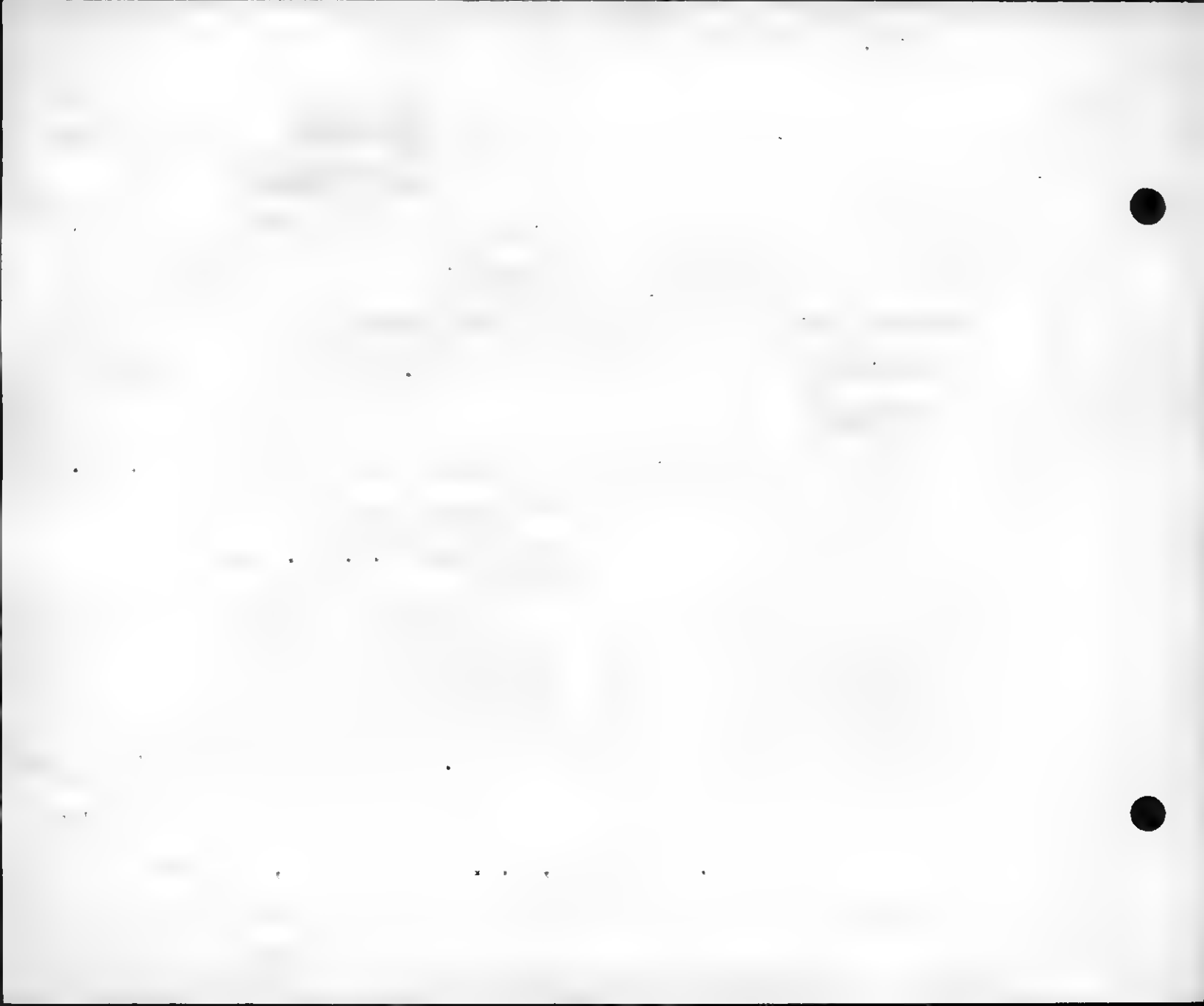
10129

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1015

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Greensboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Boyce Mill Road</u>	
3. NAME OF DECEASED (Type or print) <u>Geneva L. Pearson</u>		4. DATE OF DEATH <u>7</u> Month <u>11</u> Day <u>19</u> Year <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1910</u>
9. AGE (In years last birthday) <u>57</u> yrs		10. IF UNDER 1 YEAR <u> </u> Months <u> </u> Days <u> </u> Hours <u> </u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>No Record</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Richard Pearson Greensboro, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic C.V.D. with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1, 1966</u> to <u>July 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1967</u> , and that death occurred at <u>3:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Charles H. Stonestifer</u> M.D.		22b. DATE SIGNED <u>July 14 '67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Stonestifer, M.D.</u>		22d. ADDRESS <u>Greensboro, Maryland</u>	
23a. BURIAL, CREMATION, <u>Burial</u>	23b. DATE THEREOF <u>7-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	23d. LOCATION (City or town) (County) (State) <u>Greensboro, Md.</u>
24. FUNERAL DIRECTOR <u>J. E. Bercais</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Greensboro Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>JUL 18 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

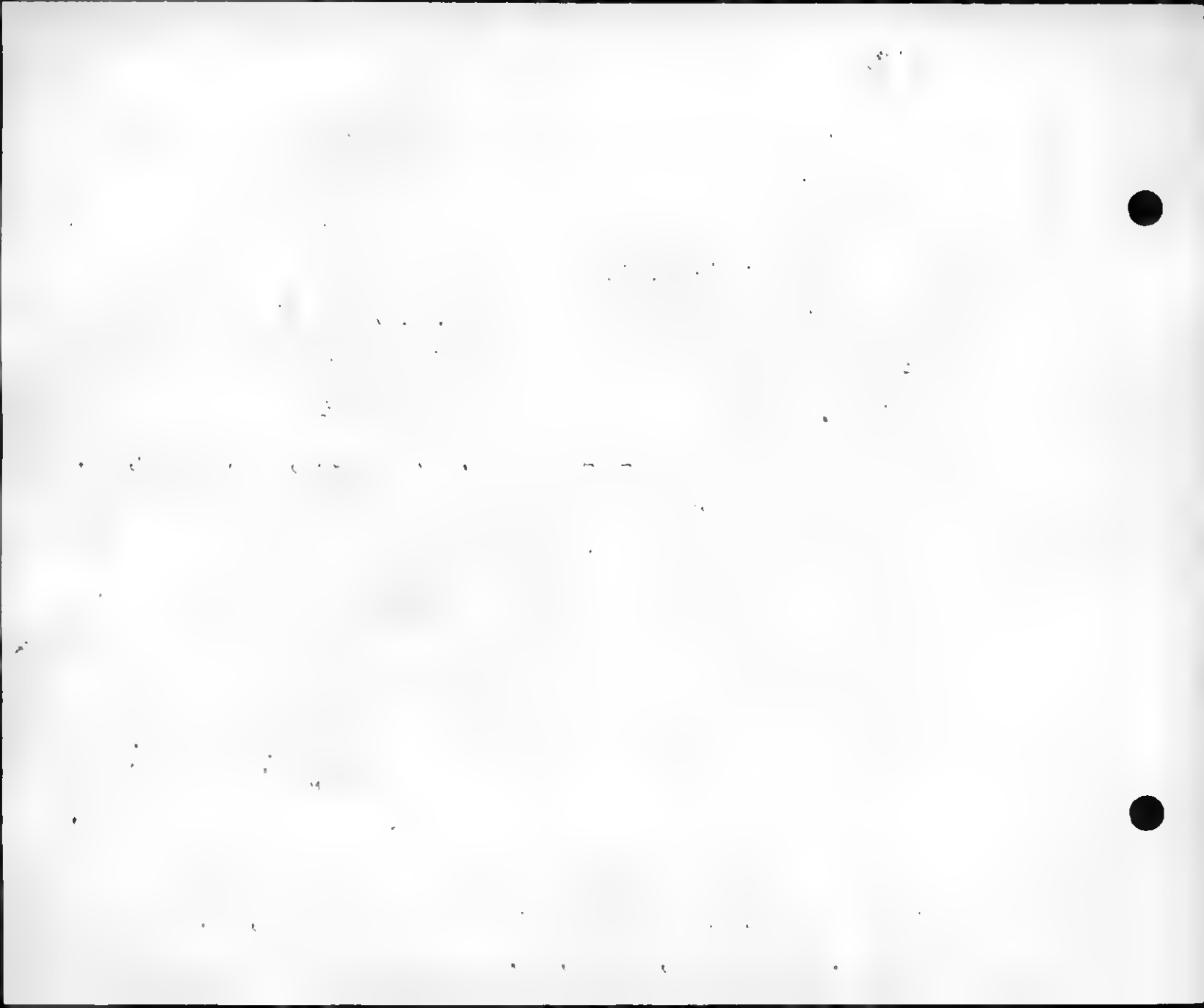
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10130

CERTIFICATE OF DEATH

10131

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton (Rural)		c. LENGTH OF STAY IN TB 4 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton (Rural)		d. STREET ADDRESS RFD #2 Box 59	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #2 Box 59		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clara Elizabeth Price		4. DATE OF DEATH Month July Day 1 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 3, 1882
9. AGE (In years and birthday) 84 yrs		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Talbot Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E. Andrew		14. MOTHER'S MAIDEN NAME Sallie Davis	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 215-44-5830A	
17. INFORMANT Mrs. Henry Gannon, RFD, Easton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure + 201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Myocardial Infarction, old (c) Atherosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 4 hours Yes Yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 11/28 , 19 63 , to 7/1 , 19 67 , that (I) (the hospital) last saw the deceased alive on 7/1 , 19 67 , and that death occurred at 3:30 AM , from causes and on the date stated above.			
22a. SIGNATURE S. Krech, Jr.		22b. DATE SIGNED 7.3.67	
22c. PHYSICIAN'S NAME (Type) S. KRECH, JR.		22d. ADDRESS EASTON, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/3/1967	
23c. NAME OF CEMETERY OR CREMATORY Spring Hill		23d. LOCATION (City or town) (County) (State) Easton, Md.	
24. FUNERAL DIRECTOR MAURICE E. NEUNAM & SON, Easton, Md.		25a. REC'D BY REGISTRAR JUL 10 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

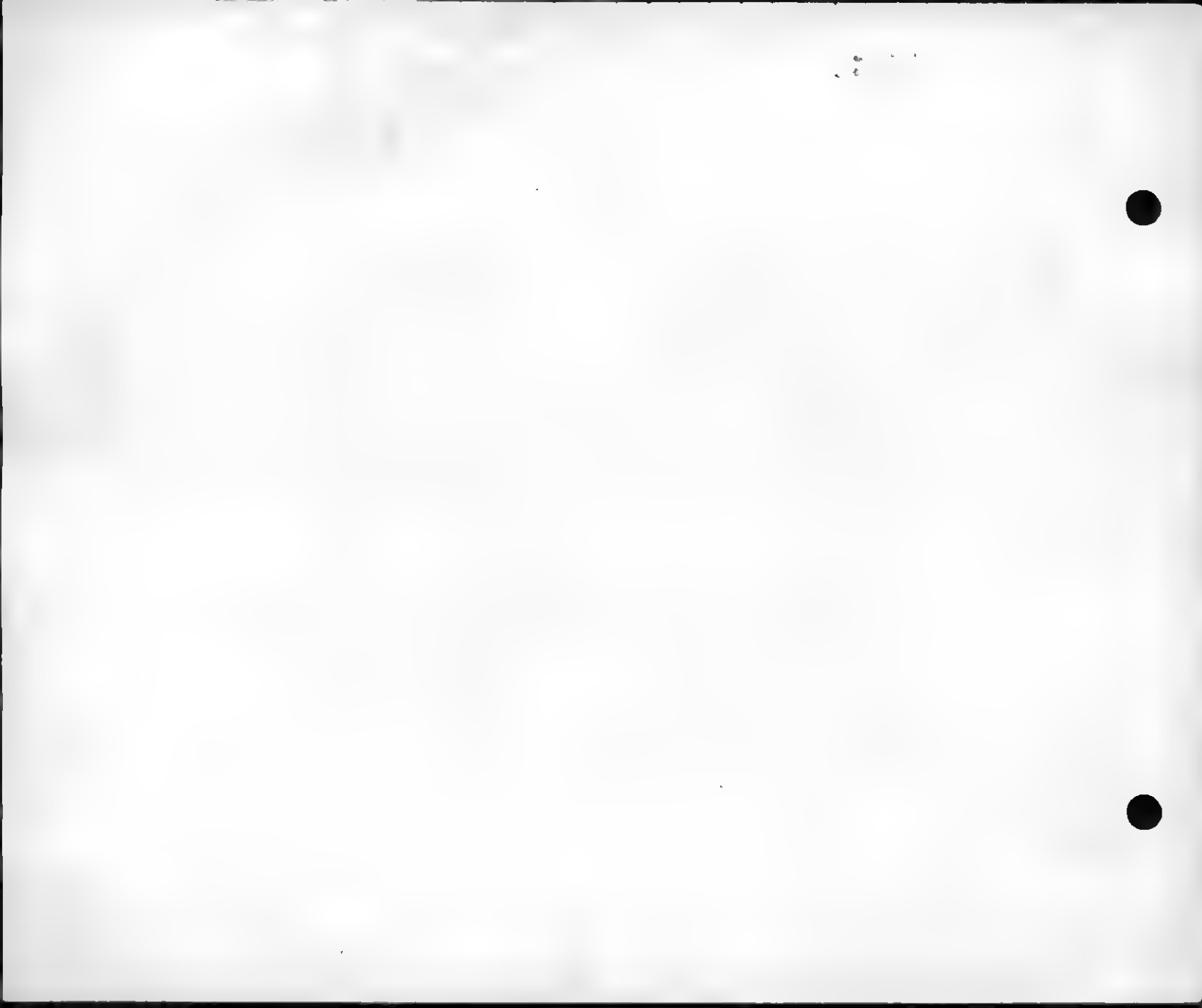
10131

CERTIFICATE OF DEATH

20132

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>L</u> Last <u>Richards</u>		4 DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>SEPT 27, 1886</u>
9 AGE (In years not birthday) yrs <u>80</u>		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12 CITIZEN OF WHAT COUNTRY <u>USA</u>	
13 FATHER'S NAME <u>JOSEPH LOCKE</u>		14 MOTHER'S MAIDEN NAME <u>ELIZABETH SHIPLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16 SOCIAL SECURITY NO <u> </u>	
17. INFORMANT <u>MRS. DOUGLAS BENNINGTON</u>		Address <u>GREENSBORO, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> DUE TO (b) <u>Phlebotomies</u> DUE TO (c) <u> </u> (Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.)			INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, severe arteriosclerosis, Leg ulcer</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>27 June, 1967</u> to <u>26 July, 1967</u> that (I) (we) last saw the deceased alive on <u>26 July, 1967</u> , and that death occurred at <u>10:38</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>7-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>JULY 30, 1967</u>	23c. NAME OF CEMETERY OR CREMATOR <u>DENTON</u>	23d. LOCATION (City or town) (County) (State) <u>DENTON MD</u>
24. FUNERAL DIRECTOR <u>Charles Moore Denton</u>		25a. REC'D BY REGISTRAR <u>JUL 28 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



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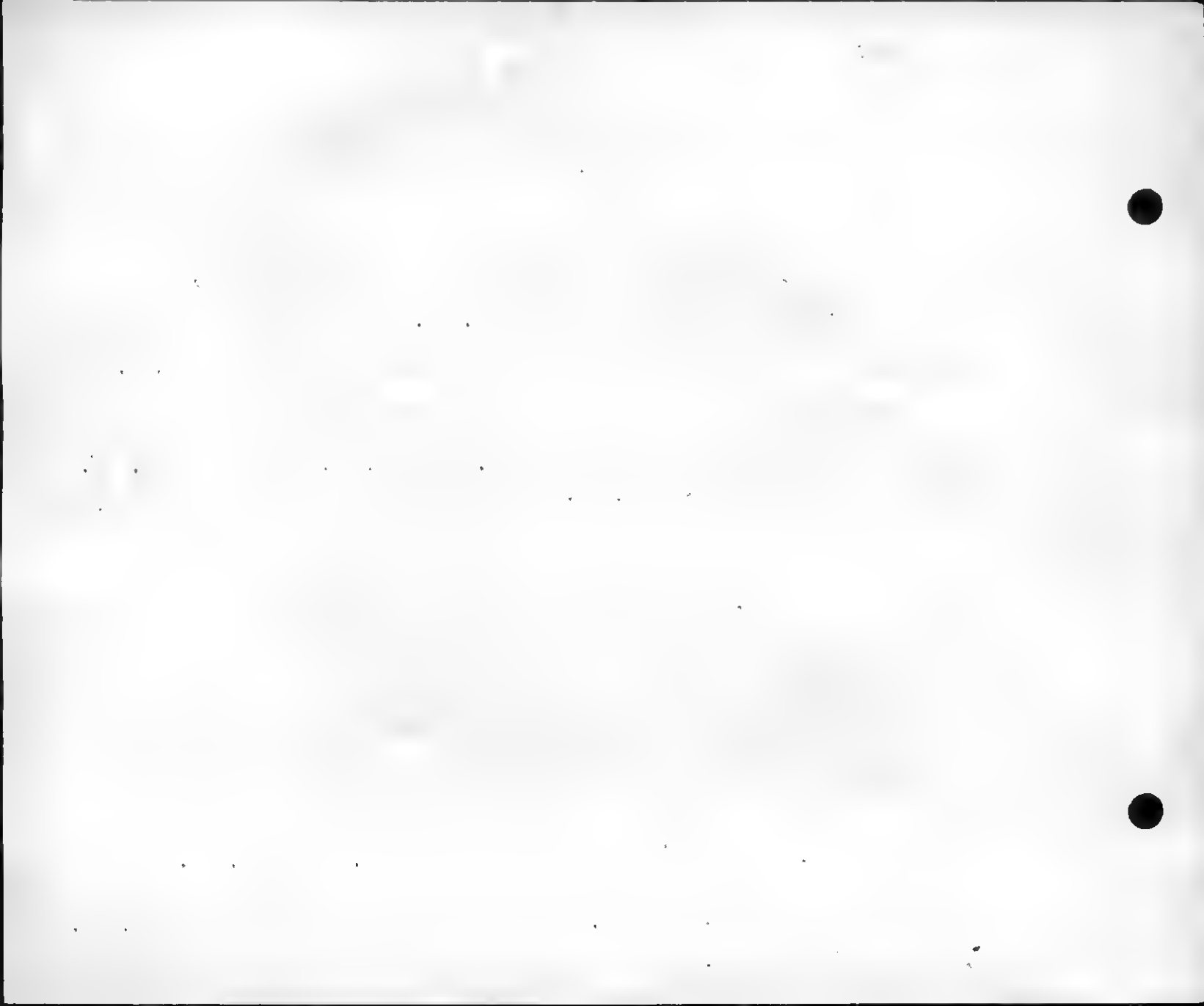
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10132

CERTIFICATE OF DEATH

10133

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>OSCAR</u> Middle <u>HERMAN</u> Last <u>SCHARCH</u>		4 DATE OF DEATH <u>July 13,</u> 19 <u>67</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>Jan. 22, 1890</u>
9 AGE (in years last birthday) <u>77</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) <u>Talbot Maryland</u>		12 CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Amil Scharch</u>		14 MOTHER'S MAIDEN NAME <u>Mary Niblett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Daisy C. Scharch</u>		Address <u>Tilghman, Md.</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Quinria</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO <u>Chronic Heart Fail</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>old Cerebral Vascular</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5-11</u> , 19 <u>67</u> , to <u>7-14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-14</u> , 19 <u>67</u> , and that death occurred at <u>12:30</u> PM, from causes on and on the date stated above.			
22a. SIGNATURE <u>R. Lane Wroth</u>		22b. DATE SIGNED <u>7-14-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Lane Wroth</u>		22d. ADDRESS <u>St. Michaels, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 16, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Tilghman, Talbot, Md.</u>	
24. FUNERAL DIRECTOR <u>Marion E. Newnam</u>		25d. REC'D BY REGISTRAR <u>Easton, Md.</u>	
25a. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>JUL 18 1967</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

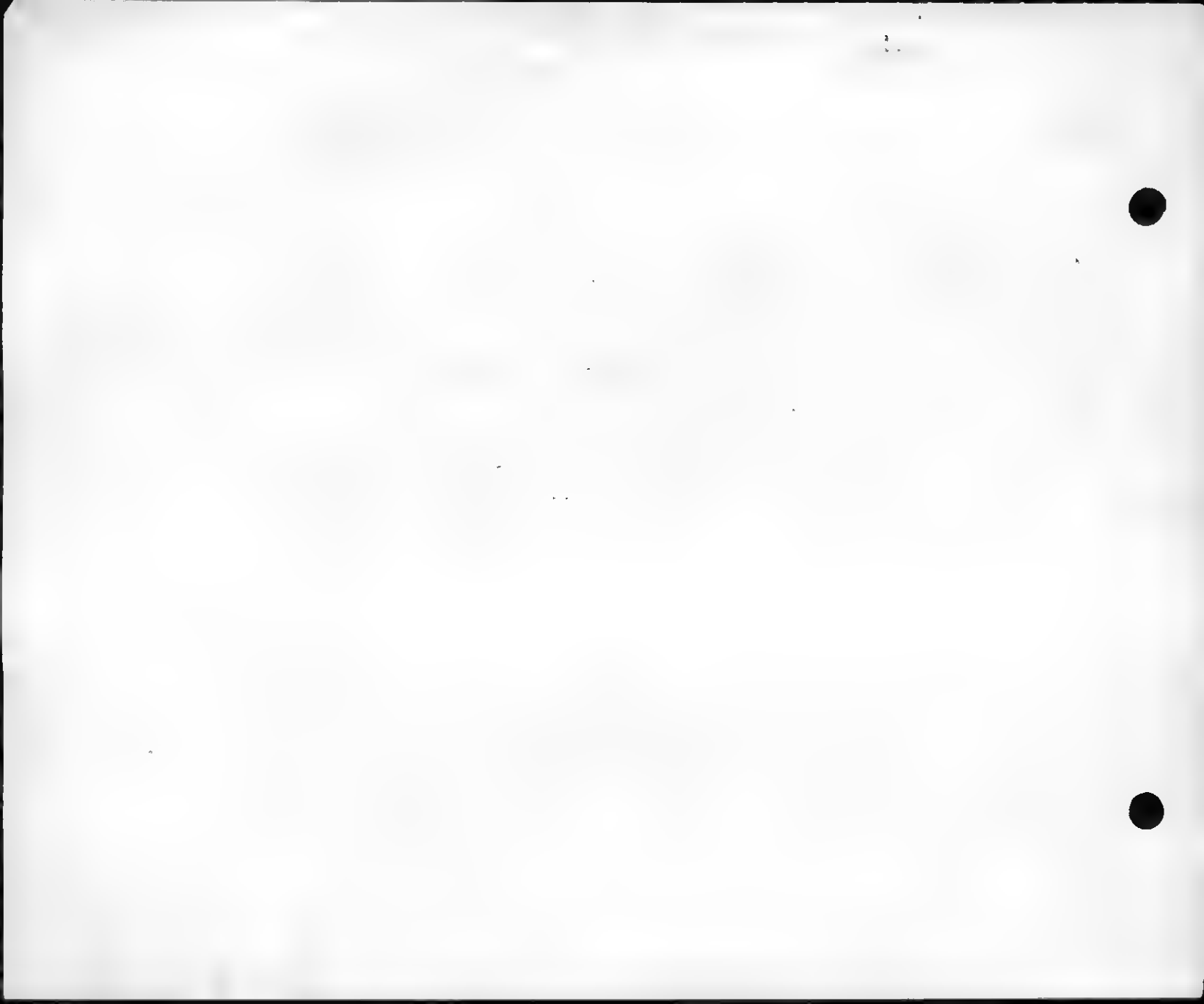
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10133

CERTIFICATE OF DEATH

10134

1 PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if inst. in residence before admission) <input checked="" type="checkbox"/> a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON MD</u>				c. LENGTH OF STAY IN 1b <u>11 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL QUEENSTOWN</u>				d. STREET ADDRESS <u>Wye Institute, Inc.</u>			
a. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MEMORIAL HOSPITAL</u>				b. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>DENALD</u> Middle <u>JAY</u> Last <u>SHANK</u>				4 DATE OF DEATH Month <u>7</u> Day <u>28</u> Year <u>1967</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1-17-17</u>	9 AGE (In years last birthday) <u>57</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>		IF UNDER 24 HRS Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive in Education</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Non-Profit Foundation</u>		11 BIRTHPLACE (County & State or foreign country) <u>Barberton Summit Co, Ohio</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>JESSE EARL SHANK</u>				14 MOTHER'S MAIDEN NAME <u>Lillian JUNKER</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>089-26-4296</u>		17 INFORMANT <u>Wife</u> Address <u>Mrs. Ruth R. Shank, Queenstown Md.</u>			
18a. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malignant glioblastoma Multiforme</u> <u>193.4</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>MONTH</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>June 1, 1967</u> to <u>7/28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/28</u> , 19 <u>67</u> , and that death occurred at <u>7:15</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>S. Krecht, Jr.</u>		22b. DATE SIGNED <u>7/29/67</u>		22c. PHYSICIAN'S NAME (Type) <u>S. KRECHT, JR.</u>			
22d. ADDRESS <u>EASTON, Md.</u>		22e. MED. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
<u>CREMATION</u>		<u>August 1, 1967</u>		<u>Cedar Hill Crematory</u>		<u>Washington D.C. 20023</u>	
24. FUNERAL DIRECTOR <u>James H. Batten, Jr., Batten Bros., Centerville, Md.</u>		25a. REG. BY REGISTRAR <u>AUG 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

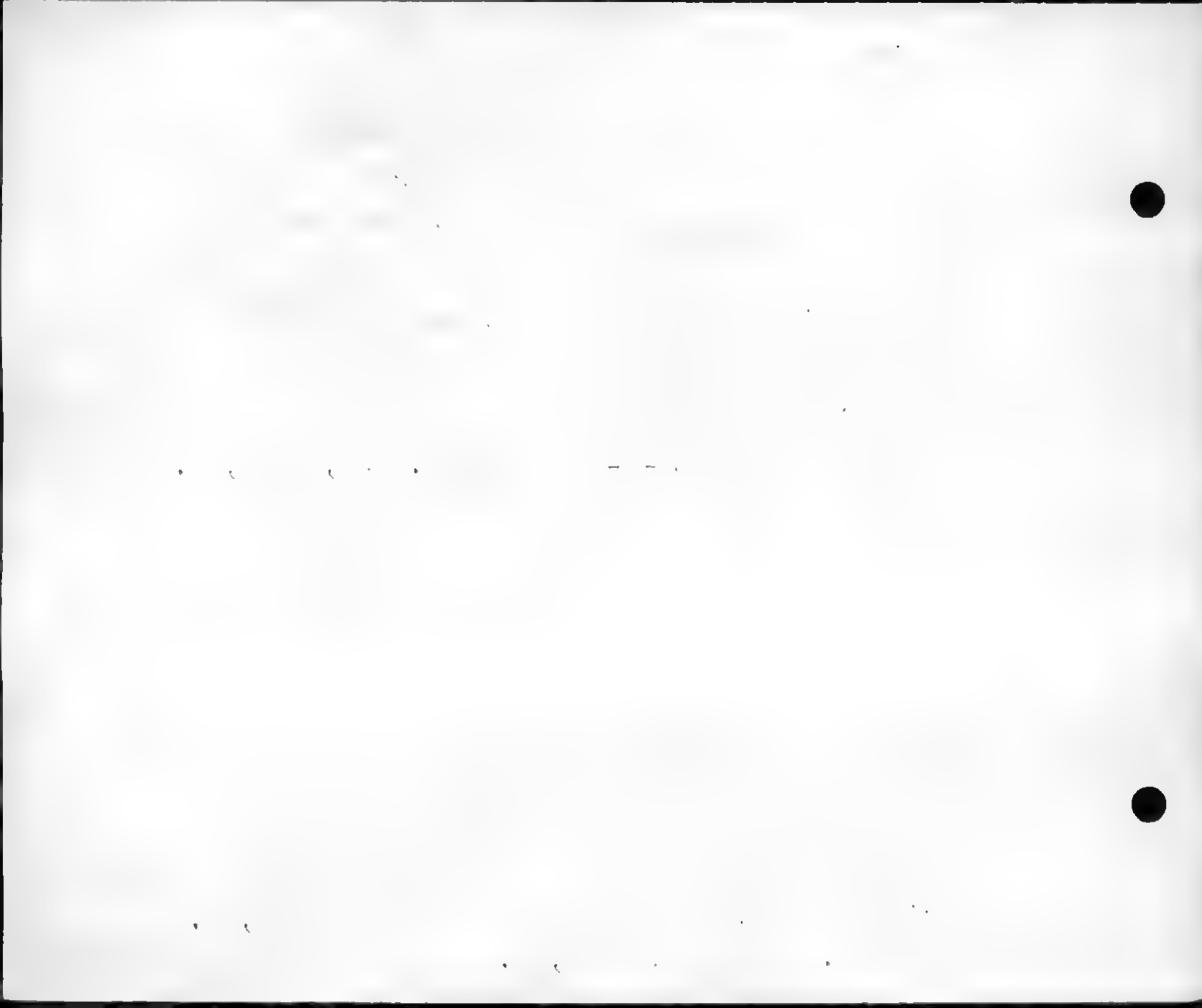
FOR STATE
HEALTH DEPT.

10134

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #. Filed for burial, cremation, or removal
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11569

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Elizabeth</u> Last <u>Smith</u>				4 DATE OF DEATH Month <u>7</u> Day <u>30</u> Year <u>1967</u>			
5 SEX <u>Female</u>		6 COLOR OR RACE <u>white</u>		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <u>12/28/1908</u>	
9 AGE (In years, last birthday) <u>59</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>USA</u>				13 FATHER'S NAME <u>Henry Cecil</u>			
14 MOTHER'S MAIDEN NAME <u>Lula Foster</u>				15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>			
16 SOCIAL SECURITY NO. <u>219-07-3354</u>				17 INFORMANT <u>Watson E. Smith, Easton, Md.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1341 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Stephen P. Carney</u> M.D. EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
22 DATE SIGNED <u>7-30-67</u>							
23a. BURIAL, CREMATION, or other disposition (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
<u>Burial</u>		<u>8/2/1967</u>		<u>Spring Hill</u>		<u>Easton, Md.</u>	
24 FUNERAL DIRECTOR <u>MAURICE E. NEUNAM & SON, Easton, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 8 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10135

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8/25/67 kk 11570

1 PLACE OF DEATH a COUNTY Talbot MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE FLORIDA b COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Markalee	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First Middle Last Jesse James Smith		4 DATE OF DEATH Month Day Year 7 31 1967	
5 SEX m	6 COLOR OR RACE e	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country)		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14 MOTHER'S MAIDEN NAME	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17 INFORMANT		Address	
18 CAUSE OF DEATH (Enter only one cause per line or (a), (b) and (c)) PART DEATH WAS CAUSED BY 443x ACVD - pulm. emphysema IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Louis O'Neely		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WELTY		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY The Anatomy Board of Maryland, Baltimore, Md.	23d LOCATION (City or Town) (County) (State)
24 FUNERAL DIRECTOR Harrison S. Leonard & L. Michaels		25a REC'D BY REGISTRAR DATE AUG 9 1967	
		25b REGISTRAR'S SIGNATURE Richard A. Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10136

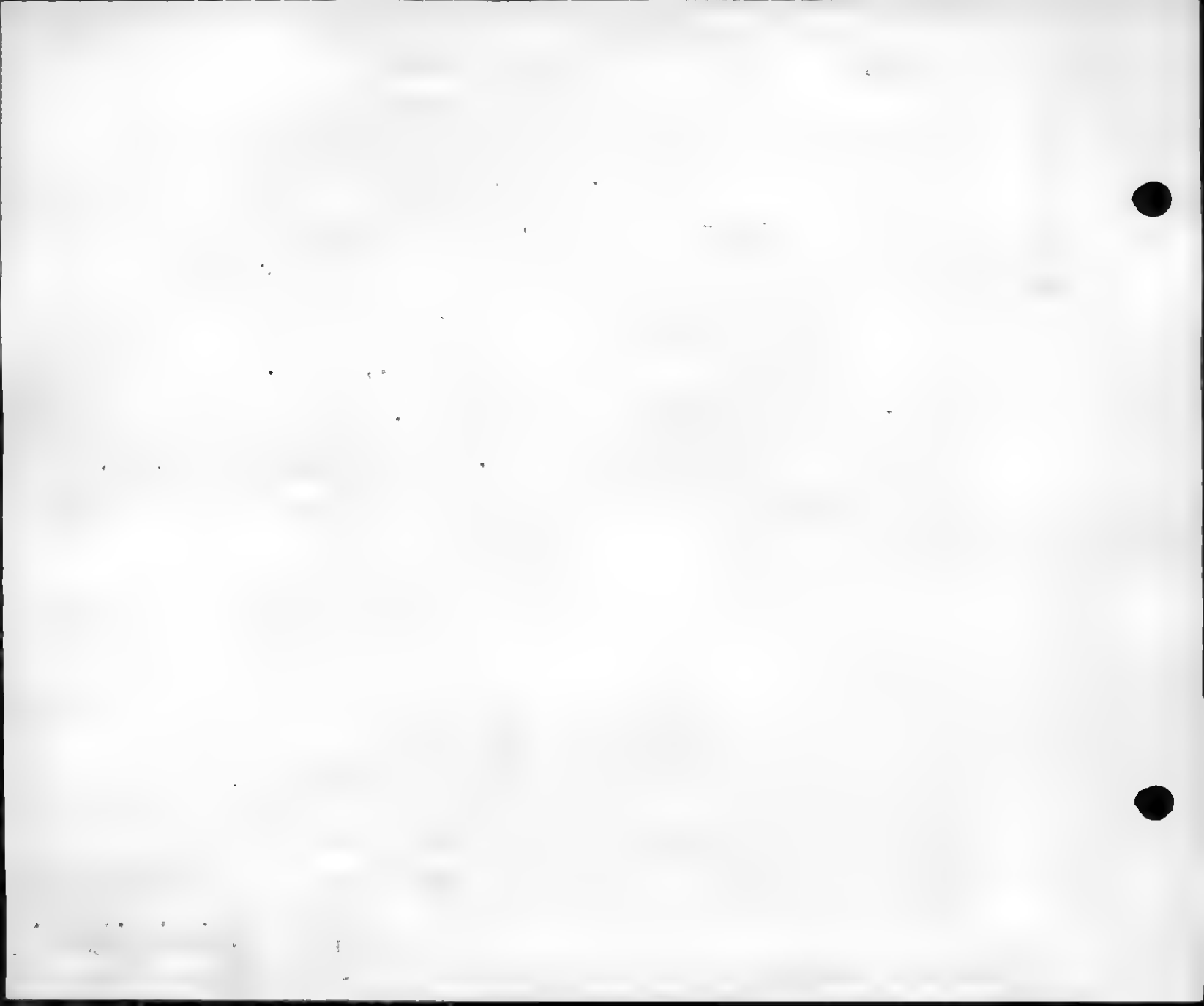
Item a Film G391 7/16/67 kk

CERTIFICATE OF DEATH

10136

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY TALBOT MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE MD. b. COUNTY TALBOT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. LENGTH OF STAY in 1b 3Mo.3 days.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOUSE IN THE PINES- EASTON, MD.		d. STREET ADDRESS St Aubins Ter.	
3. NAME OF DECEASED (Type or print) First MARY Middle V. Last SMITH		4. DATE OF DEATH Month July Day 19 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 3-4-1884
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State or foreign country) Philia., Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unk-		14. MOTHER'S MAIDEN NAME Anna W. Othoson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO unk	
17. INFORMANT Mrs. Russell Starr, Easton, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of the bladder 1014 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 16 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Conary insufficiency		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 1966, to 19 July , 1967, that (I) (we) last saw the deceased alive on 12 July 1967, and that death occurred at 5:45AM , from causes and on the date stated above.			
22a. SIGNATURE Sept O Carney		22b. DATE SIGNED 7-19-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/21/67	
23c. NAME OF CEMETERY OR CREMATORY St Georges		23d. LOCATION (City or Town) (County) (State) St Georges, N. C., Del.	
24. FUNERAL DIRECTOR Jay D. Haverin, Easton, Md.		25a. REC'D BY REGISTRAR JUL 21 1967	
		25b. REGISTRAR'S SIGNATURE John J. Haverin	



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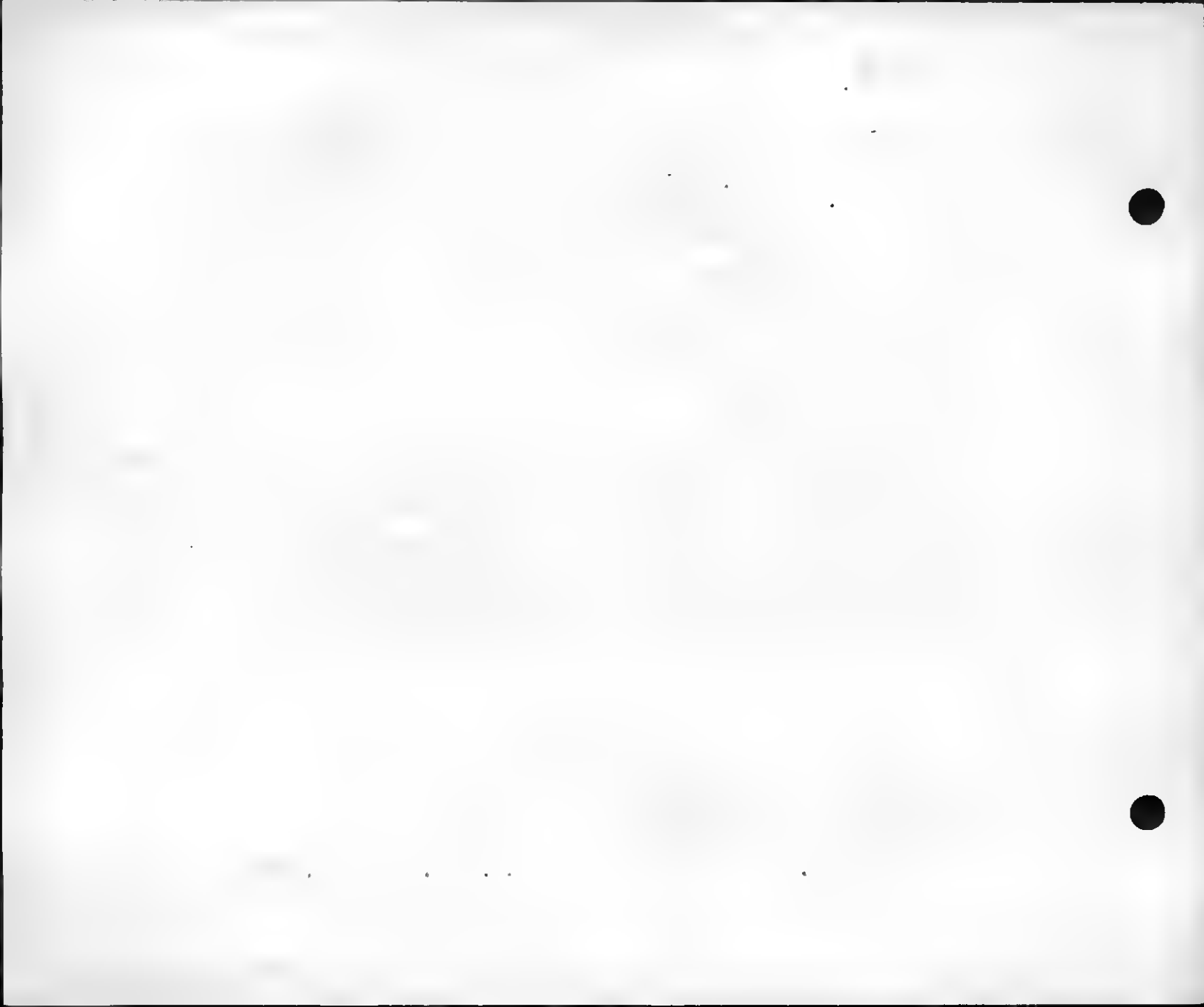
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10137

CERTIFICATE OF DEATH

10136

1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FABTON				c. LENGTH OF STAY IN TB 5 hrs. 10 min.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS —			
3. NAME OF DECEASED (Type or print) Samuel First Middle Last Steilke				4. DATE OF DEATH July 19 - 1967 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 3, 1880	9. AGE (n years last birthday) 86 yrs	F UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. WATERMAN			10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD		11. BIRTHPLACE (County & State or foreign country) TALBOT COUNTY, MD		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME GUSTAVS STEILKIE				14. MOTHER'S MAIDEN NAME EFFIE BROWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 2-17-36-1388			
17. INFORMANT J.S. STEILKIE				Address RFD#1 EAST NEW MARKET, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hypoxia DUE TO Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) Arteriosclerosis DUE TO Cardiovascular (c) 10 yrs				INTERVAL BETWEEN ONSET AND DEATH			
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 July 1967 to 19 July 1967 . That (I) (we) saw the deceased alive on 19 July 1967 , and that death occurred at 3:27 P.M. from causes and on the date stated above.							
22a. SIGNATURE R. Lane Wroth				22b. DATE SIGNED 3-20-67		22c. PHYSICIAN'S NAME (Type) R. Lane Wroth M.D.	
22d. ADDRESS St. Michaels, Maryland				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, or other disposal (Specify) BURIAL		23b. DATE THEREOF JULY 22, 1967		23c. NAME OF CEMETERY OR CREMATORY BOZMAN CEMETERY		23d. LOCATION (City or town) (County) (State) BOZMAN, MARYLAND	
24. FUNERAL DIRECTOR Edmond St. Michaels, Md.				25a. REC'D BY REGISTRAR JUL 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

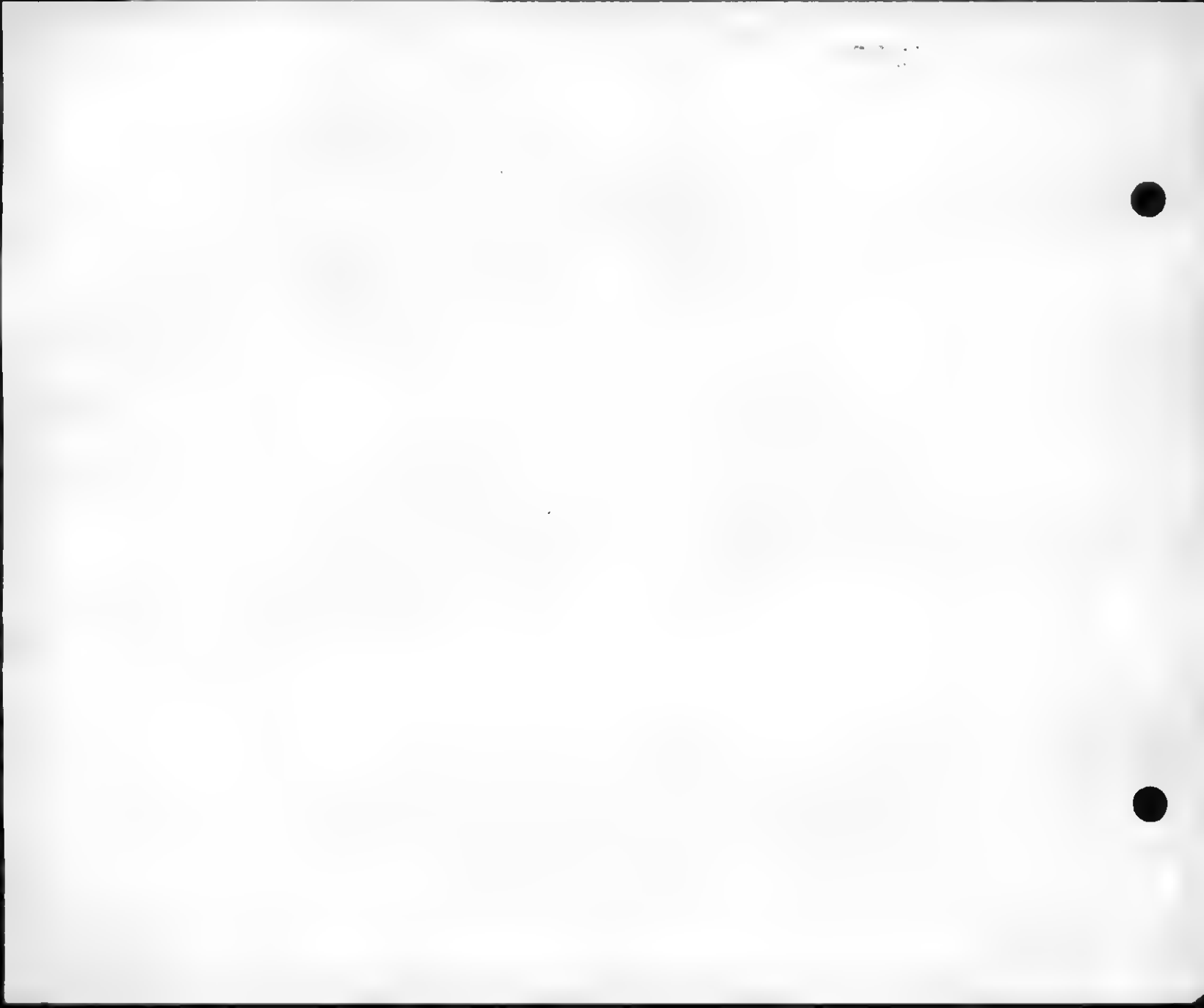
10138

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11572

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Orange</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Winter Garden</u>	
c. LENGTH OF STAY IN 1b <u>20 1/2 hrs</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Rt. #1 Box 226</u>	
3. NAME OF DECEASED (Type or print) <u>Beverly Miranda Summers</u>		4. DATE OF DEATH <u>7 26 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-67</u>
9. AGE (In years last birthday) <u>7</u>		10. IF UNDER 1 YEAR <u>7</u> Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Ind</u>	
11. BIRTHPLACE (State or foreign country) <u>Ind</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Wallace Bennett, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Florine Summers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17. INFORMATION <u>FLORINE SUMMERS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>broncho pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lewis J. Welty</u> EXAMINER'S NAME (Type) <u>WELTY JR</u>		22. DATE SIGNED <u>7-28-67</u>	
23a. BURIAL (CREMATION) REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>7-27-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL HOSPITAL</u>		23d. LOCATION (City or town) (County) (State) <u>E STON TALBOT MD.</u>	
24. FUNERAL DIRECTOR ADDRESS		25a. REC'D BY REGISTRAR <u>AUG 8 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

7-214133



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remayne carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

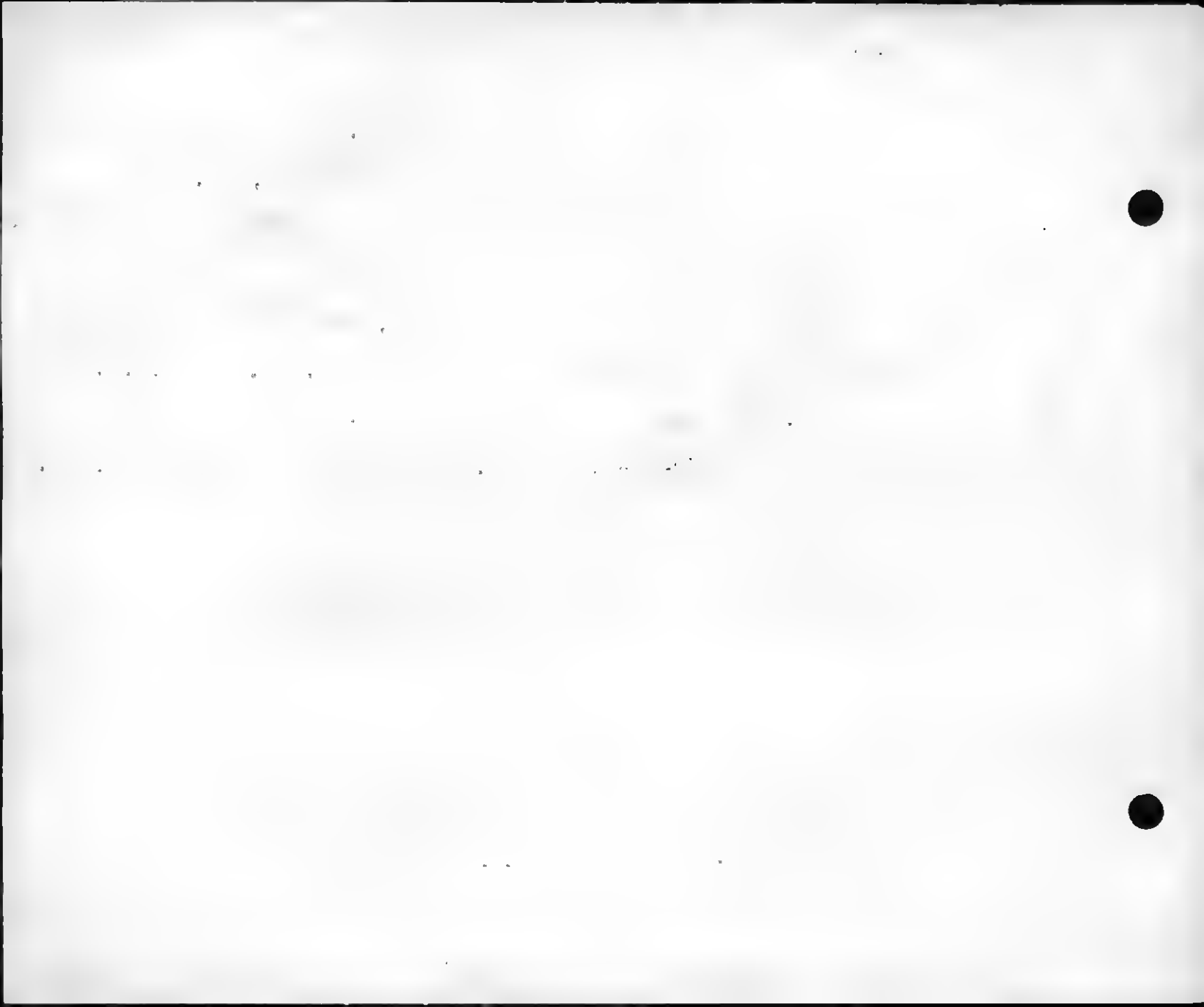
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10139

CERTIFICATE OF DEATH

0137

1 PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Caroline</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg, Md. rural</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Memorial Hospital</i>		d. STREET ADDRESS <i>(Hynson)</i>	
3 NAME OF DECEASED (Type or print) First <i>Lee</i> Middle <i>Koy</i> Last <i>Venable</i>		4 DATE OF DEATH Month <i>7</i> Day <i>16</i> Year <i>1967</i>	
5 SEX <i>male</i>	6 CO. OR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>March 29, 1896</i>
9. AGE (In years last birthday) <i>71</i> yrs		IF UNDER 1 YEAR Months <i>7</i> Days <i>16</i> Hours <i>19</i> Min <i>7</i>	IF UNDER 24 HRS Months <i>7</i> Days <i>16</i> Hours <i>19</i> Min <i>7</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>same</i>	
11 BIRTHPLACE (County & State, or foreign country) <i>Caroline Co. Md.</i>		12 CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward W. Venable</i>		14. MOTHER'S MAIDEN NAME <i>Nettie M. Nichols</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16 SOCIAL SECURITY NO. <i>213-18-5954</i>	
17. INFORMANT <i>Mrs. Marie Nagel</i>		Address <i>Federalsburg, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute myocardial infarction, arterial</i> DUE TO <i>arrhythmia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>17 day</i>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c TIME OF INJURY Month, Day, Year Hour 'a.m. <i>19</i> p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>20 June 1967</i> to <i>16 July 1967</i> , that (I) (we) last saw the deceased alive on <i>16 July 1967</i> , and that death occurred at <i>10:30</i> A.M., from causes and on the date stated above.			
22a SIGNATURE <i>Stephen P. Carney</i>		22b. DATE SIGNED <i>7-17-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Stephen P. Carney</i>		22d. ADDRESS <i>M.D. Easton, Maryland</i>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<i>Burial</i>	<i>7/19/67</i>	<i>Concord Cemetery</i>	<i>Federalsburg, Md - rural</i>
24 FUNERAL DIRECTOR <i>Harvey W. Wilson</i>		25a REC'D BY REGISTRAR <i>Federalsburg Md</i>	
25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>UL 20 1967</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

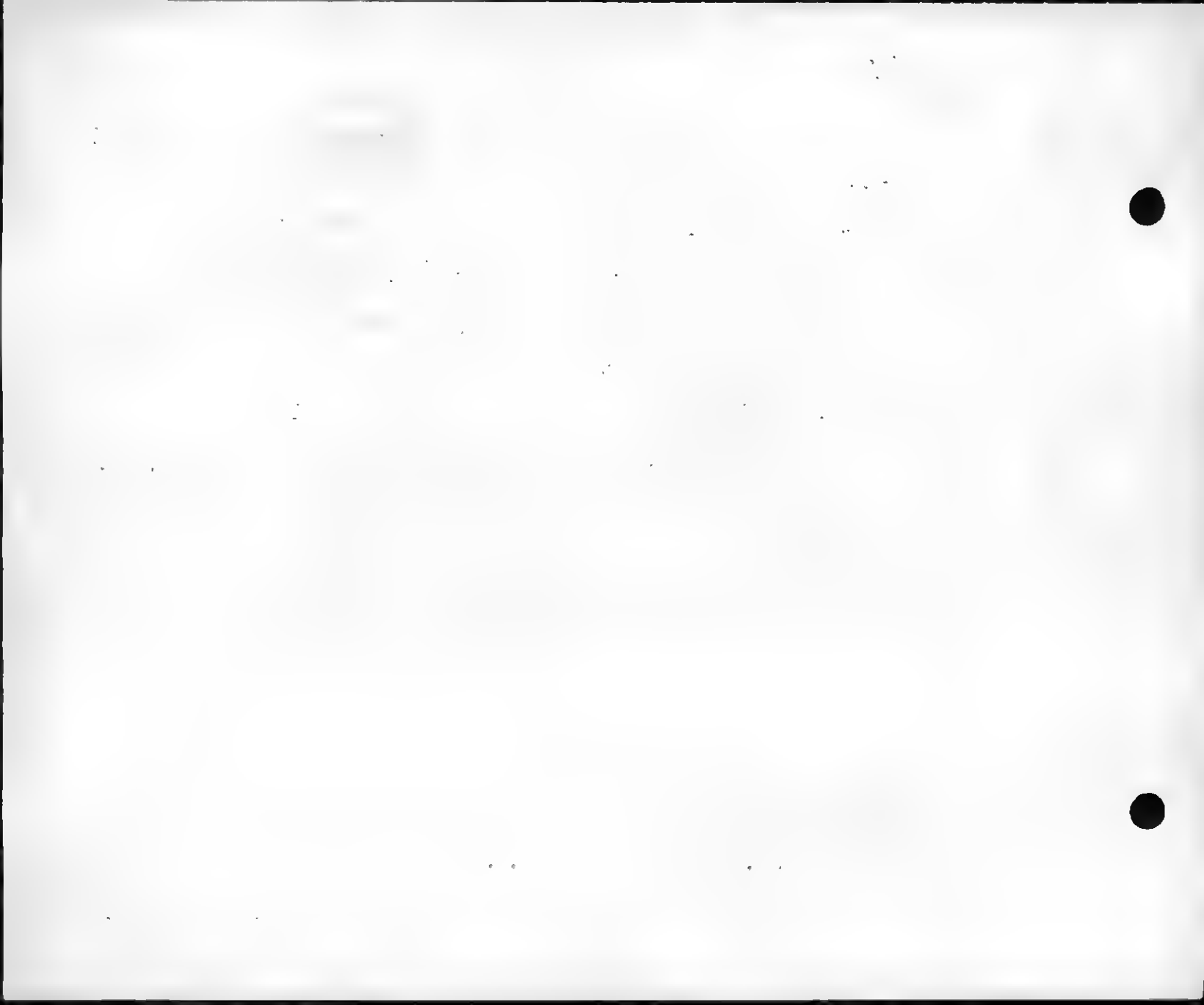
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10140

CERTIFICATE OF DEATH

30123

1 PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memoria Hospital</u>		d. STREET ADDRESS <u>3 Earle Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Faye Lewis Warrington</u>		4 DATE OF DEATH <u>July 19 1967</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 19, 1886</u>
9. AGE (In years last birthday) <u>81</u> YRS.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during past working life, even if retired) <u>Book Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Sussex-Delaware</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles P. Warrington</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Collins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16 SOCIAL SECURITY NO <u>213-01-8281</u>	
17. INFORMANT <u>Mrs. Cleo Cooper</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from <u>March, 1962</u> to <u>19 July, 1967</u> , that (I) (we) last saw the deceased alive on <u>19 July 1967</u> , and that death occurred at <u>10:45</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen P. Carney</u>		22b. DATE SIGNED <u>7-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen P. Carney</u>		22d. ADDRESS <u>M.D. Easton, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or town) (County) (State)
<u>Burial</u>	<u>7-22-67</u>	<u>Spring Hill Cemetery</u>	<u>Easton, Talbot, Md.</u>
24 FUNERAL DIRECTOR <u>Maurice E. Newman & Son, Easton, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 25 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10141

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10133

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>2450N</u>			c. LENGTH OF STAY IN <u>Do AC 2 1/2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Trappe</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Mace</u> Last <u>Webb</u>				4. DATE OF DEATH <u>1</u> Month <u>17</u> Day <u>19</u> Year <u>67</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 2, 1901</u>		9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dart</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Webb</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Taylor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Mrs J. Mace Webb, RFD, Trappe, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute coronary insufficiency</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Howard F. Kinnamon</u>		EXAMINER'S NAME (Type) <u>Howard F. Kinnamon</u>		M.D. <u>M.D.</u>		22. DATE SIGNED <u>7/19/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 20 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Cambridge, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Compton F/S Cambridge, Md.</u>				25. REC'D BY REGISTRAR <u>101 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10142

10149

1. PLACE OF DEATH a. COUNTY Talbot		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Easton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge Vienna	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOUSE IN THE PINES -EASTON, MD.		d. STREET ADDRESS unk	
3. NAME OF DECEASED (Type or print) NELLIE H. WEBB		4. DATE OF DEATH Month July Day 6 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/27/1880
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. AGE (In years last birthday) 87 yrs.	
10a. KIND OF BUSINESS OR INDUSTRY Home		10b. BIRTHPLACE (County & State, or foreign country) Vienna, Maryland	
11. FATHER'S NAME James Ashtland Webb		12. CITIZEN OF WHAT COUNTRY? USA	
13. MOTHER'S MAIDEN NAME Alice Larrimore		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
15. SOCIAL SECURITY NO. unk		16. INFORMANT Mrs. Lawrence Maryanov, Cambridge, Maryland	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic Nephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Heart Disease DUE TO Inanition		INTERVAL BETWEEN ONSET AND DEATH 2 months 10 yrs 3 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1965 to July 6, 1967 , that (I) (we) last saw the deceased alive on July 4, 1967 , and that death occurred at 12:15 AM , from the causes and on the date stated above.			
22a. SIGNATURE Lawrence Maryanov M.D.		22b. DATE SIGNED 7/6/67	
22c. PHYSICIAN'S NAME (Type) Lawrence Maryanov		22d. ADDRESS Cambridge, Md 21613	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 8 1967	
23c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery		23d. LOCATION (City, town or county) (State) Vienna, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE McCombe F/S Cambridge, Md.		25a. REC'D BY REGISTRAR JUL 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Juge			

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